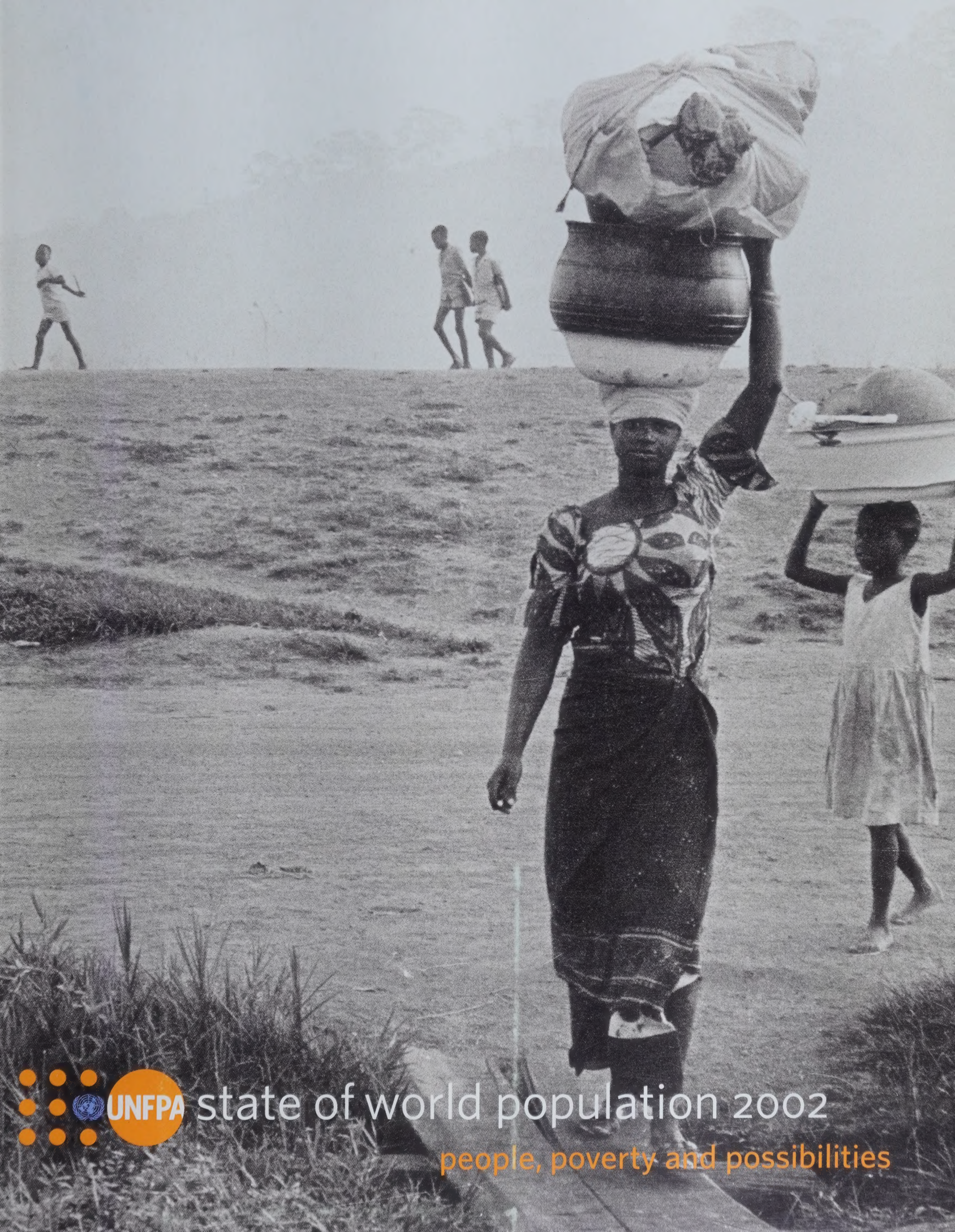

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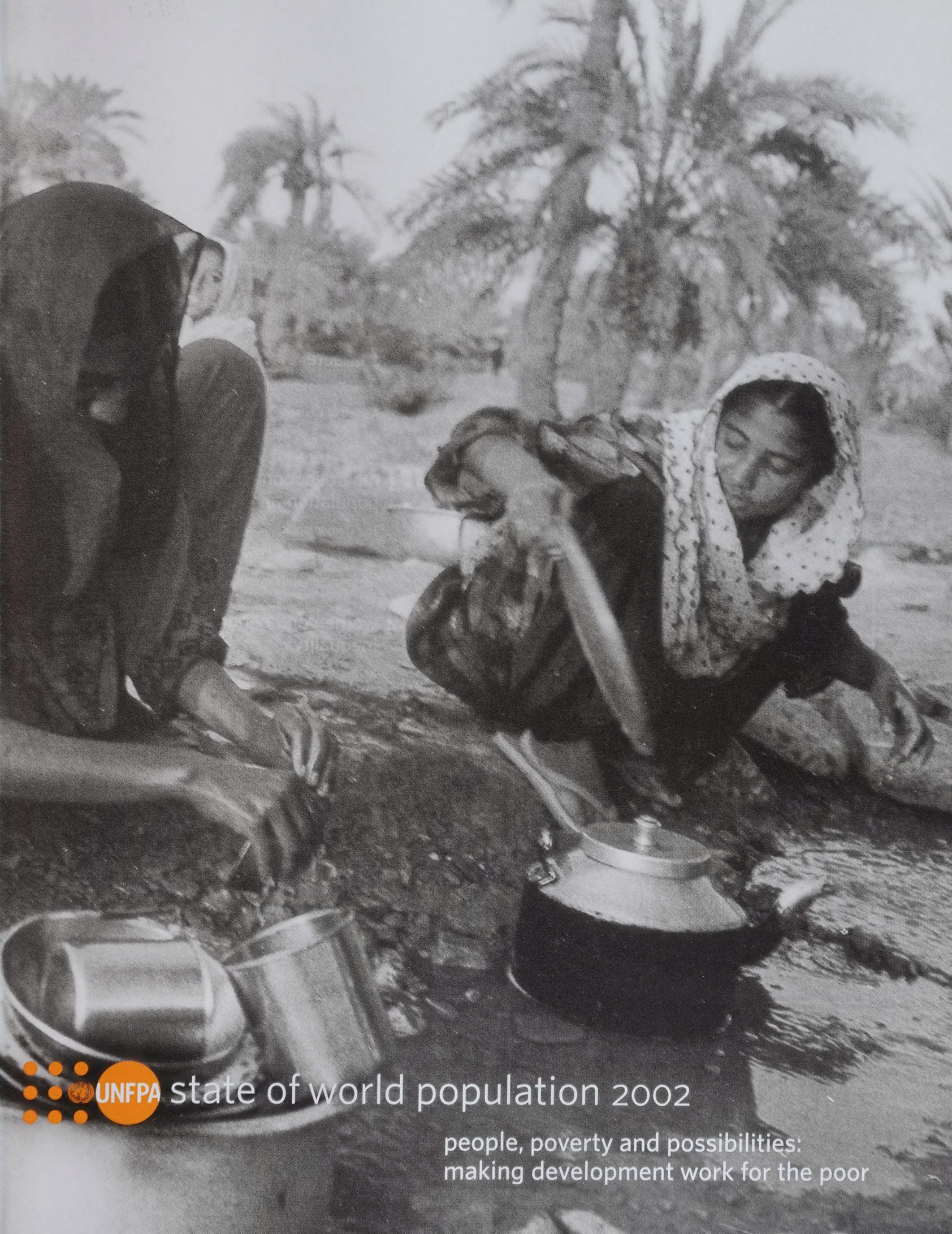

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state of world population 2002

people, poverty and possibilities: making development work for the poor

chapters

"Development has often bypassed the poorest people, and has even increased their disadvantages. The poor need direct action to bring them into the development process and create the conditions for them to escape from poverty."

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1 overview

Introduction

Attacking poverty directly—as a matter of human rights, to accelerate development and to reduce inequality within and among nations—has become an urgent global priority. World leaders have agreed on a variety of new initiatives, including the United Nations' Millennium Development Goals (MDGs). This year's *State of World Population* report is a contribution to the discussion and a guide to action.

The number of people (3 billion) living on $2 a day or less[1] is the same as additions to world population since 1960. Of course, the relationship is not direct, but population cannot be ignored in the discussion about poverty and how to end it.

- Fertility and population growth are highest in the poorest countries. The least-developed countries will most likely triple their populations by 2050, from 600 million in 1995 to 1.8 billion.[2]
- Population age structures have an impact on development: a high proportion of young dependents holds back economic growth.
- Urban growth is fastest among poor populations. Many of the new urban migrants are very poor, driven by environmental collapse or economic hopes or hardship.

Development has often bypassed the poorest people, and has even increased their disadvantages. The poor need direct action to bring them into the development process and create the conditions for them to escape from poverty.

The world's nations agreed as long ago as 1994 that population and development work is central to this purpose. The 1994 International Conference on Population and Development (ICPD) addressed population and reproductive health concerns within a broad development framework, stressing the need to incorporate diverse population issues—including growth, location, age distribution and movement, and their evolving dynamics—in addressing issues of sustainable development.

The ICPD adopted important goals, including better reproductive health, universal education and gender equality, all within the context of human rights.[3] Work towards these goals fits seamlessly into the MDGs, and reinforces progress towards them.

Work towards population goals helps reduce poverty in several ways. Two of the most important:

- Slower population growth has encouraged overall economic growth in developing countries.[4] Since 1970, developing countries with lower fertility and slower population growth have seen higher productivity, more savings and more productive investment. Incomes, the usual measure of poverty, have risen across the board.
- Incomes do not tell the whole story. Successful developing countries have also invested in universal health care, including reproductive health, and education. They have moved to reduce gender inequality and remove obstacles to women's particpation in the wider society. These social investments promote human rights. They improve human well-being, help close the gaps between the poor and the better off, and reduce the disadvantages under which poor people labour. Poor people themselves measure the quality of their lives in this broader way.

Chapter 2 looks at ways to describe and measure poverty.

THE DEMOGRAPHIC WINDOW Social investments help reach the goal of slower population growth. Improving health care, education and opportunities for women is a matter of human rights; it empowers women, and it also results in smaller families overall. Within a generation this downturn in fertility opens a demographic window, a period in which a large group of working-age people is supporting relatively fewer older and younger dependents. The demographic window is a unique opportunity for countries to invest in economic growth. The window opens only once and not for long. Within another generation it closes again, as populations age and dependency increases once more.

Taking advantage of the demographic window has accounted for a third of the annual economic growth of the East Asian "tigers". Mexico, Brazil and some other countries have also taken advantage of their demographic window. Others have been less successful. The poorest countries are a long way from opening the demographic window, but investment now will safeguard the future. Investment will also protect the present. It will save women's lives, and protect their families. It will empower them to take control of their lives.

Evidence also suggests that the economic gains from declining fertility change the distribution of wealth to the benefit of the poor.

The "macro" effects of population on development are discussed in Chapter 3.

1 ECONOMIC UNCERTAINTY The world economic situation poses challenges to progress towards the MDGs. Overall, in the 1990s gross domestic product (GDP) per capita grew by 1.6 per cent a year in developing countries. But these slow gains were unevenly distributed. The per capita GDP growth of the poorest countries in the 1990s was slower than in the 1980s.

Lower-middle-income countries also had poorer economic performance in the 1990s than the 1980s. Transitional and developing economies in Europe and Central Asia actually declined in the 1990s. In 1999–2000 GDP growth per capita in low-income countries in this region was 2.2 per cent per year. Similar rates held regionally in Latin America and the Caribbean, South Asia, and the Middle East and North Africa. Sub-Saharan African per capita economic performance grew by only 0.6 per cent. While extreme income poverty declined in the 1990s, much of that was due to progress in a few countries in Asia.

The new decade started with even greater uncertainty. Recent global reductions in trade, a spreading economic contraction and new banking and finance crises as in Brazil and Argentina are posing challenges to economic growth.

Economic growth alone may not be enough to ensure progress towards the MDGs. Whatever gains are made need to be directed to reduce poverty.

Population, Development and the Millennium Development Goals

The international community has committed itself to an ambitious goal: cutting in half the number of people living in absolute poverty by 2015. To meet the eight MDGs (see box, next page), world leaders have adopted a series of specific and detailed targets for life expectancy (a way of measuring health), education, housing, gender equality, openness of trade, and environmental protection.

The new goals recognize that poverty concerns dignity, opportunity and choice as well as income. Escaping poverty is not a purely individual act. It depends on the support of institutions—the family, the state, civil society, the private sector, the local community and cultural organizations—the political, economic and social environment they create, and the support and opportunities they provide.

The most ambitious effort in human history towards human well-being should be an inspiration, but inspiration must be underpinned by some practical understandings.

The first condition for success is respect for national sovereignty: each country will decide its own needs. National culture and history, and decades of experience with international cooperation, will inform and shape action.

Second, the Millennium Development Goals reinforce each other; all are priorities and should be worked on together. They are a selection from the recommendations of the international conferences of the 1990s, whose analyses and action plans remain effective.

Third, action towards the specific goals does not exclude and may require action in other areas. These include debt relief, trade regimes and investment arrangements as well as development assistance.

Finally, success requires commitment from all countries, and from the private as well as the public sector.

The great series of international conferences in the 1990s developed an agenda for social action against poverty, centred on individual men and women. Key aims were improvements in health and education, both as personal goals and as public goods.

In the area of health, the recent World Health Organization (WHO) and World Bank initiative in health and macroeconomics strongly supports this agenda, focusing attention on combating malaria, tuberculosis and HIV/AIDS, as well as other infectious and environmental diseases.[5]

In the area of population, the 1994 ICPD endorsed WHO's broad positive definition of health as "not merely the absence of disease or infirmity" but "a state of complete physical, mental and social well-being",[6] and agreed that the human right to health includes reproductive health. The Conference also endorsed the goals of universal education and closing the gender gap in education. The international consensus, before and after the ICPD, explicitly recognizes the importance of demographic trends—population growth, location, movement and age structure, fertility and mortality—on all aspects of development.

Increased attention has been directed to places with large populations of refugees or displaced persons. Natural calamities, conflict and social upheaval have left millions of people beyond the reach of functioning institutions or systems of governance. Emergencies can be short- or long-term. Providing immediate services, lasting development efforts and the means of ultimate resettlement are important contributions to combating poverty. Progress towards the MDGs must include people in such desperate circumstances.

The international understanding on population has been affirmed and repeated[7] so often that its demographic impact is often taken for granted. Policy makers confidently build demographic assumptions—about declining fertility, for example—into their plans. But good demographic outcomes depend on good policies, based on good data. Successful action depends above all on empowering individuals and couples to make free choices.

2 **FAMILY PLANNING PROGRAMMES WORK** Family planning programmes and population assistance encourage lower fertility. They accounted for almost one third of the global decline in fertility between 1972 and 1994, over and above the contribution of education, the share of agriculture in the labour force, GDP per capita, the proportion living in urban areas, nutrition levels and time period. The effects of programmes on fertility were particularly strong in Asia (accounting for more than two thirds of the decline), intermediate in Latin America and the Arab States and weak in Africa.

Effects on unwanted fertility are even clearer. In some analyses, population programmes account for 40 to 50 per cent of the change. Programmes reduce unwanted fertility by making reproductive health services accessible, and involving non-governmental organizations (NGOs) and the private sector. Universal access to services would enable women and their partners to have only the children they want; national comparisons indicate that absence of universal access alone makes a difference of up to one third in modern contraceptive use.

Education, information and communication are important for the success of population programmes. Better information makes it possible and acceptable for communities and families to discuss and act on all sorts of issues related to reproductive health: how to reduce maternal, infant and child deaths and prevent unplanned births; how to encourage discussion and mutual decision-making by women and their partners; how to free women for broader social participation; and how to reduce the stigma and confront the threat of HIV/AIDS.

Continued progress depends on continued investment, domestic and international. Since 1969, the United Nations Population Fund (UNFPA) has been the largest multilateral source of population assistance, providing some $6 billion for population programmes.

Reproductive Health, Family Planning and Population Promote Millennium Development Goals

Goal 1: Eradicate extreme poverty and hunger

Voluntary family planning can help people to have as many or as few children as they want and to decide when they will have them.

Fertility reduction opens the "demographic window", an opportunity for accelerated social and economic development.

- Large families dilute the assets of poorer households. Unwanted births deepen household poverty.
- Smaller families allow more investment in each child's health and education.
- Improved data on people and their needs will advance policy development and the targeting of development programmes—and improve accountability.
- Migration within and between countries can bring benefits and pose challenges in both sending and receiving areas. Policies can help maximize the gains to poor communities and individuals.
- Better child spacing reduces competition for food within the household and improves children's nutrition.

Goal 2: Achieve universal primary education

- Attempts to achieve universal education have left out poor children.
- Large numbers of children in poor families mean that some children get no education. For others, education may be delayed, interrupted or shortened.
- In poor families, girls are more likely than boys to be deprived of education.
- Educational continuation depends on avoidance of unwanted pregnancies. Early initiation of sexual activity increases the risk of school dropout. In sub-Saharan Africa between 8 and 25 per cent of dropout rates are the result of pregnancy.
- Early marriage interrupts girls' schooling.

Goal 3: Promote gender equality and empower women

- Progress towards gender equality starts with the common indicators of literacy and education. It continues with health care, including personal, voluntary control over fertility. It is important that families and societies accept women's wider social participation, and remove obstacles to it.
- Girls and women need environments where they are safe from gender-based violence, including on the way to, from and in school.

Goal 4: Reduce child mortality

- Infant and child mortality are highest for the youngest mothers and after closely spaced births.
- High fertility reduces the provision of health care to children.
- Unwanted children are more likely to die than wanted ones.
- A mother's death increases the risk that her children will die.

Goal 5: Improve maternal health

- Care in pregnancy, during and after childbirth, and emergency obstetric care save women's lives.
- Pregnancy is riskiest earliest in life. Over 100,000 women are at risk of obstetric fistula each year, and over 2 million women have already been injured and stigmatized.
- A woman's lifetime risk of maternal death and illness depends on the number and safety of her pregnancies.
- Family planning saves women's lives. It reduces unwanted pregnancy, unsafe abortion and maternal death. Women's empowerment will enable them to address the social conditions that endanger their health and lives.

Goal 6: Combat HIV/AIDS, tuberculosis, malaria and other diseases

- Half of new HIV infections are among young people. Preventing infection means enabling young people to protect themselves from sexually transmitted diseases. This includes teaching abstinence outside marriage, fidelity within it and responsible behaviour at all times, including the responsible use of condoms.
- Male and female condoms must be available as needed. Poor countries need systems to guarantee an adequate supply of reproductive health commodities, and support in establishing and supplying the system.
- Integrated reproductive health programmes that serve a variety of needs through the life cycle will encourage health service use and provide additional opportunities to address health needs holistically. Changing age structures will require long-term adjustments in health systems.
- The pandemic has serious implications for the attainment of the other goals, particularly 1-5.

Goal 7: Ensure environmental sustainability

- Balancing resource use and ecological requirements will depend critically on population growth, location and movements, on patterns of resource consumption, and management of waste.
- Rapid growth of poor rural populations puts enormous stress on local environments. Poor people need technologies to mediate their demands on resources. They also need better education and health services, including reproductive health, to improve well-being and bring down fertility. Appropriate policies will reduce urban migration and promote sustainable rural population growth.
- The sustainable improvement of the lives of slum and shanty dwellers will depend on policies to address high urban growth rates, the result of natural increase and migration.

Goal 8: Develop a global partnership for development

- Population and reproductive health programmes have lagged in the least-developed countries, with their high levels of mortality and unwanted fertility. They will benefit most from higher international assistance and debt forgiveness, and domestic resources for health and education—and their effective use. They need affordable prices for essential drugs for treating HIV/AIDS, malaria and tuberculosis, and a secure supply of contraceptives.
- Between 2000 and 2015 nearly 1.5 billion young men and women will join the 20-24 age group. They, and hundreds of millions of teenagers, will be looking for work. If they have jobs they will drive economic growth; if not they will fuel political instability.

Other Key Issues

POVERTY AND GENDER Women are disproportionately represented among the poor. Most poor women are in households headed by a man, but some of the poorest women are in women-headed households. An increasing number are widows.

Reducing the "gender gap" in health and education reduces individual poverty and encourages economic growth. The effects are strongest in the poorest countries. Economic growth and rising incomes reduce gender inequality, but they do not break down all barriers to women's social participation and development. There must be specific action to recognize and remove gender bias based on human rights principles.

The most obvious impact of gender bias is in sexual violence, within and outside the home. One woman in three will experience violence at some time in her life.[8]

Gender bias in the economic sphere can be hard to pin down, but its results are real and practical. For example, gender bias may stand in the way of interventions such as improving water and energy supply, which reduce the time women have to spend fetching water and gathering cooking fuel. Women use the time saved to earn additional income and participate in community affairs.

As incomes rise, poor families increase their spending on children's education, health care and nutrition. Girls generally benefit more than boys. Effects accumulate over generations as educated mothers invest more in their daughters' schooling.

Special information and service programmes can have greater impacts among poor women, because the better off already have several ways to find information and services. Studies in Bangladesh found that participation in programmes that combine maternal and child health and family planning with poverty alleviation produce greater reductions in child mortality, particularly among girls, in the poorest groups compared to the richest groups. Combining the two programmes improved their effectiveness.[9]

GENDER DIFFERENCES IN THE USE OF RESOURCES Women do a wide range of paid and unpaid work, in the home and outside of it. Much of this work is not included in national accounting systems. This invisibility translates into incapacity: what countries do not count, they do not support.

Measuring gender inequality is not easy. But by any measure, women in poverty fall well short of their male counterparts in resources available to them, and in control of joint resources. Redressing the balance will depend partly on the ability of women and men to build partnerships for increasing their joint resources. An important part of the partnership will be shared and informed decision-making about sex and reproduction, about family responsibilities and the upbringing of children, especially girls.

Poor women live with their poverty, but they are not passive. They must work hard merely to survive. Their capabilities are reduced by illiteracy, poor health and malnutrition. With whatever energy remains, they take every opportunity to escape their poverty.

Obstacles to their struggle are external and often institutionalized. Traditional practices do not allow for social mobility. Gender roles are prescribed and rigid. Those who feel their interests threatened by change, such as individuals or groups who wield power in traditional society, often oppose initiatives to empower poor women.

Change can create opportunity for women. New job opportunities created by development, for example, in textiles or electronic assembly, often fall to women rather than men. This can strengthen their position within the family and their ability to participate in family decision-making, but men who feel threatened by their partners' new-found capacity may respond with violence.

The urban setting is more flexible and offers more opportunity, but carries its own costs and obstacles for poor women. Removing traditional barriers opens opportunity, but also opens the possibility of economic and sexual exploitation. The traditional extended family protects women to some extent but also inhibits them. In the urban setting, protections as well as inhibitions may be removed.

Reducing gender inequality can accelerate economic growth and have a powerful impact on poverty. Comparing East Asia and South Asia between 1960 and 1992, South Asia started with wider gender gaps in health and education and closed them more slowly. If gender gaps had closed at the same rate in the two subregions, South Asia would have increased its real per capita annual growth in GDP by 0.7 to 1.0 per cent.[10]

Gender issues are discussed in Chapter 4.

3 **WIDOWS AND THE ELDERLY POOR** As life expectancies increase over the coming decades, hundreds of millions of women are expected to become widows—with important implications for the provision of social security, health care and housing.

In the richer countries, elderly people living alone are more likely than other groups to be in the bottom tenth of the income distribution, and most of the elderly living alone are women. In Australia, Chile and the United States, elderly women are more likely than elderly men to qualify for means-based social assistance.

When economies of scale are considered, single widows, widows living with unmarried children, and female household heads (all of whom tend to live in relatively small households) are more likely to be poor. In some African and Asian countries widows without adult sons are especially vulnerable.

It is common to think of widows as elderly. But in many countries many widows are young, because of men's shorter life expectancy and a wide age difference between spouses. Wars tend to kill prime-age males. HIV/AIDS increases the risk that many young women will be widowed.

Widows already make up much of the world's older population. By the mid-1990s more than half of all women over 65 in Asia and Africa were widows, while only 10-20 per cent of men were widowers.

The number of people aged 60 and older is projected to more than triple in the next half century, from 593 million to 1.97 billion, increasing the share of older people in the population from 10 to 22 per cent.

COPING WITH CHANGE—HEALTH AND EDUCATION Social arrangements and practices reflect economic realities. Much of the current social tension and unease in developing countries reflects the struggle to adapt to economic change. The poor are often constrained by tradition in this struggle, since they do not have the power to make other choices.

Although all societies give high value to health and education as private goods, they tend to be valued less as public goods. This may be changing. If health and education and other means of empowering the poor to escape from poverty are seen as a matter of national security, they may be given more priority as public goods.

Providing universal high-quality education and health care to a large population at a cost all can afford is a challenge for all societies. Countries with a small tax base, a shortage of vital skills and an overburdened administration make progress against heavy odds. The relative success of many developing countries in extending life expectancy and reducing illiteracy is an indicator of their commitment.

POVERTY AND HEALTH Poverty kills. Life expectancy at birth in the least-developed countries is under 50 years, compared to 77 in richer countries. The poor are more exposed to environmental health risks and to infection, the result of inadequate and overcrowded housing without sanitation or clean water, often in unhealthy areas, both urban and rural. Hunger is a daily reality for the very poor. Malnutrition predisposes people to ill health and contributes to high maternal mortality among the very poor. Unwanted pregnancies put further strain on women's health. Infection and injury associated with pregnancy and childbirth decrease women's productivity and quality of life.

The poor see poor health as one aspect of their poverty. Ill health deepens poverty. Illness is most frequently cited by the newly poor as a cause of their slide into poverty.[11] The poor have less access to health services than the better off and they are less likely to seek care when they need it. Poor people often do not use existing services because of their low quality. Even in publicly financed health systems more of the resources go to the better off.

Poor health holds back economic growth. Productivity losses from ill health could amount to roughly $360 billion per year in developing countries within two decades.[12]

WOMEN AND REPRODUCTIVE HEALTH Much of the burden of ill health, especially for women in their reproductive years, is related to sex and reproduction: more than 20 per cent in developing countries overall and 40 per cent in sub-Saharan Africa.[13]

Worry about reproductive health is part of poor women's experience of poverty. Young women especially know little about family planning, and do not perceive that it is a choice available to them. The pressures are all in the opposite direction. There is a strong bias towards early marriage and childbearing among the poor, because children and a family are seen as elements of well-being. The ideas that smaller, healthier, better-educated families also contribute to well-being—and that there are choices to be made—come later in life, too late for many women.

Sex and reproduction are sensitive topics in any society, and it is particularly hard to open the discussion about contraception for young people, even more so for the unmarried, as an option along with abstinence. Yet the discussion is essential: unwanted adolescent pregnancy is a growing problem in many developing countries, and half of all new HIV infections are among people 15-24.

Early marriage does not protect young women's health: pregnancy before the age of 18 is several times more risky than for a woman over 20. Teenage mothers are more vulnerable to injuries such as obstetric fistula, which can blight the rest of their lives if not repaired. The male partners of young women tend to be older and more sexually experienced, and more likely to be infected with HIV. Teenage women, married or not, are more likely to be HIV-positive than young men their own age.

RICH-POOR GAP IN REPRODUCTIVE HEALTH Health differentials between rich and poor are among the widest in any sphere of life. Health gaps between rich and poor are generally wider in poorer countries than richer ones, but this does not have to be so. Countries that design their health systems to promote equality can show a narrow range of difference, regardless of income.

One of the differences is that better-off people know about and can use health systems in general and reproductive, maternal and child health services in particular. A study of 44 developing countries showed that fertility is highest among the poorest and is successively lower in wealthier groups.[14] The better off have fewer children than the poor, and they also have only the children they want. Poor women want more children, but they also have more children than they want.

Unwanted pregnancy can cost a woman her life: women in the poorest countries, and the poorest women within these countries, face a risk of death as a result of pregnancy up to 600 times higher than their better-off counterparts. More than half a million women die every year from causes related to pregnancy and childbirth, almost all of them in developing countries. Many times that number face illness or injury.

Poor women in poor countries desperately need antenatal care and safe delivery services, including emergency obstetric care. They also need family planning information and services to reduce unwanted pregnancy and avoid abortion, which is often illegal and unsafe.

For the young, early marriage, social pressure and reluctance to spend public money on protecting their reproductive health increase the dangers of being both young and poor. In Latin America, for example, 15- to 19-year-olds in the poorest families are four to ten times more likely to have a child as young people from the wealthiest households.

HEALTH SECTOR REFORM SHOULD SUPPORT REPRODUCTIVE HEALTH Health sector reform is intended to improve the reach and quality of services, but health depends on more than the health sector alone. Reform will be really effective only if other areas are reformed as well, notably education, gender relations and the overall quality of governance, including new resources and better use of available ones.

4 **THE POOR SPEAK OUT** The World Bank-supported project *Voices of the Poor* vividly illustrates how poor people link poverty to high fertility and gender inequality.

From **Ghana**: "Poor men and women across the communities visited ... consider lack of money, unemployment, and having too many children as leading causes of poverty. Other causes mentioned in most communities relate to low crop yields and soil infertility, and to diseases and ill health. . . [In listing] the impacts of poverty, every single community mentions poor health or premature death.... In five communities, prostitution is identified as an impact.... Poor people often speak of their large households and the added stress this can place on meager resources and social relations. In almost every [description of] the causes of poverty, women and men have included 'unplanned births', 'lack of family planning', or 'too many children'."

From **Malawi**: "Study participants in two urban settlements ... say that some households are doing better because family planning is now more available. According to a poor woman in Chemusa, 'In the past, people were not using family planning methods and this was causing the families to have more ... so that it was difficult for most households to budget properly'."

From **Jamaica**: "A woman ... speaks for many others when she explains that a woman must have her own economic means so that 'she doesn't feel helpless'. Many women ... acknowledge their drive for financial independence and express appreciation for the greater freedom that having an income brings.... Other women advise, 'Have your own shelter and finances so you don't have to stay in an abusive relationship.' ... A woman in Cassava Piece remarks, 'More women work now, so they don't have to put up with men's foolishness.' In some urban communities women mention greater freedom to choose family planning methods."

Health care reform often means decentralization, so that local services can respond to local needs. Effective reform depends on guaranteed funding—by providing more resources and better use of available funds—and central support for services that cannot be supplied locally.

Health systems focus on treatment and cure, so specific action is needed to protect preventive services like reproductive health. Partnerships with NGOs and the private sector can be productive.

Decentralized systems can pay more attention to inequities in health service delivery. Affordable service fees can be used to improve the quality of care, but the poorest cannot afford fees at any level. Fees have meant that millions of poor people, particularly women and children, forgo the care they need.

Health issues are discussed in Chapter 5

HIV/AIDS Poverty, inequality and globalization combine to increase the impact of the pandemic. It is the major cause of death in Africa, where 28 million live with HIV/AIDS: all but 1.5 million of the 40 million currently infected people live in developing countries. It is spreading fastest in Eastern Europe and Central Asia, and is daily becoming a more serious threat in India and China.

In 2001 three million people died of AIDS, out of 22 million the disease has killed. AIDS deaths have left 13.4 million children without one or both parents, a third of all orphans. For the poor, this means increasingly relying on the grandparents' generation, but older people are often unable to cope. An increasing number of poor children are without any kind of family support.

POVERTY SPREADS HIV/AIDS Malaria, tuberculosis and sexually transmitted diseases that predispose to HIV infection are more common among the poor. Poor people know less about HIV/AIDS and are less able to protect themselves. Young women are especially vulnerable, and especially uninformed—in one African country nearly nine out of ten sexually active teenagers know nothing about HIV/AIDS. The impact of AIDS further impoverishes the families affected.

HIV/AIDS is a demographic, social and economic disaster. As it kills predominantly younger adults, the worst-affected countries are seeing the hollowing out of an entire generation in the productive age group, with all the attendant consequences: personal tragedy, families forced deeper into poverty, communities threatened, the social fabric weakened and now looming economic crisis.

In the worst-affected countries public servants and private sector employees are falling sick in increasing numbers. By 2020 economies could be 20-40 per cent smaller than expected because of the pandemic. Damage to public services such as education and health will drive the poor further into poverty. Health services have already moved out of the reach of many of the poorest because of fees for service and other charges. Education can provide a "social vaccine", but education and health systems are both collapsing as teachers and health workers die.

The pandemic shows no signs of slowing. Instead it is threatening to engulf the most populous countries of the world, India, China and Indonesia. Effective leadership has held back infection in countries such as Senegal, Thailand and Uganda, but many leaders at all levels have not yet confronted the pandemic. Despite many statements of support, members of the international community have not yet provided the resources poor countries need.

The disease spreads overwhelmingly by unprotected sexual contact, predominantly between men and women. About a third of infected mothers pass the disease to their children *in utero*. Women are more vulnerable to infection for physiological and social reasons, and sex workers are far more likely than the population at large to be infected, but the sexual behaviour of men is largely responsible for spreading the disease.

Half of all new HIV infections are among young people aged 15-24, and young women are more likely to be infected than young men their own age, reflecting their social vulnerability. Young people are ignorant of the disease and its effects, and do not know how to protect themselves against it. Many societies still do not consider this information suitable for young people, despite ample

evidence that the exercise of sexual responsibility, including abstinence, depends at least in part on accurate and timely information, and that young people will use sexual information and services in a responsible manner.[15]

Stopping the pandemic means stopping the spread of infection. Prevention calls for adequate information and services, which should include emphasis on abstinence outside marriage and fidelity within it. Treatment can help, but any cost is too expensive for the poorest people. There must be adequate supplies of male and female condoms, and the motivation for people to use them. At present, only one person in five has access to information and services to protect themselves against infection.

Calls for "behaviour change" alone will not motivate people to protect themselves, or enable them to do so. HIV/AIDS accompanies poverty, is spread by poverty and produces poverty in its turn. The infection spreads rapidly among people without confidence in the present or hope for the future.[16]

Effective strategies to turn back the epidemic must go beyond medicine and health care and reach into the community. They call for close consultation with the people they seek to assist.[17] Strong and committed leadership that leads by example as well as exhortation is a prime necessity.

The Global Fund for AIDS, Tuberculosis and Malaria will do much to combat the pandemic, if the international community provides the required funding.

HIV/AIDS is discussed in Chapter 6.

EDUCATION AND POVERTY Access to basic education as a human right has improved, but there is much more to be done. The poor have benefited less than the better off. The push for universal primary education has left out poor children. Rural/urban differentials remain large in many countries.[18]

The content and quality as well as the level of education affect children's prospects for development. Educated mothers encourage and support the education of their children.[19] They know the value of education, but they are also able to afford it. The poor cannot afford to supplement inadequate public systems with private education.

The number of siblings can affect a child's chance of education: poor families must often choose which of their children to educate. In extended families, relatives sometimes step in to cover some of the costs, but the choice falls more often on the boys, leaving the girls with little or no education. Parents may also have concerns about girls' safety at school, or going to and from school. Among older girls, pregnancy is always a risk. Even without these pressures, mothers' need for help with their many tasks often takes priority over girls' schooling. The gender gap in primary education has narrowed in many countries over the past several decades, but sometimes this is only because boys' progress has slowed.

Many children do not have the benefit of a two-parent family. The luckier ones are living in one-parent homes or fostered with relatives, but a large and growing number of children are abandoned, orphaned (increasingly by HIV/AIDS) or sold into sexual servitude. Their lives are likely to be short, painful and unhappy.

Education for the children of the poor, especially those who live outside the reach of families, calls for special efforts. Civil society helps reach out to young people outside the school system, but efforts are piecemeal in most developing countries. It requires a massive investment in both formal and informal education, inside and out of school.

HEALTH AND EDUCATION Educated mothers have healthier children. They know more about good nutrition, and there is less competition for food in smaller families. The combination accounts for 43 per cent of the reduction in child malnutrition between 1970 and 1995.

Educated women have fewer children, and fewer unwanted or mistimed births, but other influences help produce this effect. Educated women tend to come from educated families, and they know about and use health care and family planning. Education may stimulate the desire for better health care and smaller families, but education is neither a clinic nor a contraceptive. Women need services to give effect to their wishes and meet their needs.

With fewer children, families can invest more in each child's education.[20] Unwanted children will have less education if parents must pay for it, as they increasingly must.[21]

Education is discussed in Chapter 7.

How to Meet Poverty Eradication Goals

What needs to be done to halve the numbers of the poor by 2015? For countries, overall economic growth is not enough: it requires directing development efforts to the poor. The international community should take account of the context of poverty, going beyond market forces to create an international environment that encourages development.

FRAMEWORK The international conferences of the 1990s, the Millennium Summit in 2000 and the International Conference on Financing for Development in 2002 agreed on a series of goals intended to halve poverty by 2015. Many of the Millennium Development Goals, including health goals, depend on agreed population goals, including the universal availability of family planning and other reproductive health services, on empowering women, and on achieving gender equity and equality.

The WHO/World Bank Commission on Macro-economics and Health recognized that population and reproductive health are central to the attainment of the health goals of the Millennium Summit and to the entire development agenda. Improving health goes further than identifying and treating disease. Preventive health efforts, including reproductive health, must have high priority.

The MDGs include reduction in maternal, infant and child mortality. Improved reproductive health services will help meet these goals through direct service provision and the indirect benefits of better birth spacing.[22] Reproductive health services also deliver education, counselling and condom distribution that help fight HIV/AIDS. These services can go directly to the poor.

Population trends will affect prospects for sustained improvement in poverty beyond the 15-year horizon of the MDGs. Lower fertility and slower population growth will temporarily increase the relative size of the workforce, opening a historic one-time demographic window, an opportunity for investment in economic growth; but in the poorest countries population momentum and high levels of unwanted fertility delay this opportunity. The HIV/AIDS pandemic may close the demographic window before it opens, because the death of young adults stunts the growth of the working-age population. The disease both devastates the present and steals the future.

RECOMMENDATIONS The essential requirements are to target assistance directly to the poor, to reduce their costs and to give them a voice in policies and programmes that affect them.

Governments, communities, the private sector and the international community must cooperate more closely, to make the best use of limited domestic and international resources and exploit comparative advantage. Closer coordination among the different parts of the United Nations system will be an important part of the process.

Donors should encourage partnerships among governments and NGOs, with particular attention to incorporating the views of the poor in the design, implementation and monitoring of programmes. This participatory approach allows feedback on priorities and process.

Reproductive health—pre- and post-natal care, safe delivery, family planning and prevention of sexually transmitted infections (STIs) and HIV/AIDS—is most effective as part of an integrated package. Health sector reform in many poor countries includes integrated health service packages, but special care is needed during the transition to protect services for the poor and ensure that they have a voice. This is especially important for women, who have most to gain from effective reproductive health services. Programmes must address the special needs of especially vulnerable groups such as the young, migrants and refugees.

The diverse needs of the poor are often best addressed in integrated programmes. Empowering women by granting small loans through microcredit arrangements has shown its effectiveness, especially when other services such as literacy and reproductive health are included in the package.

In all population-related programmes, better data systems mean better information, awareness, effectiveness and feedback. Countries need better data on the benefits and costs of programmes, where the resources for them come from, and how to use them most effectively. They need data on demographic conditions and trends to improve policy-making for development.

Universal education is a goal on which there is universal agreement. But the aim will be thwarted without the enrolment and continuation of poor children, especially girls. These should include special efforts to avoid early marriage, unwanted pregnancy and HIV infection.

Investments in education bring substantial returns. Female education, apart from empowering the woman herself and widening her life choices, is particularly cost-effective because benefits pass on to her children. However, the investment can be dissipated if lack of choice about the number, timing and spacing of children and rigid gender roles reduce women's social and economic participation.

RESOURCES The International Conference on Population and Development agreed on the cost of a package of reproductive health and other needs—$17.0 billion a year in the year 2000, to increase to $18.5 billion in 2005, $20.5 billion in 2010 and $21.7 billion in 2015. The international community would provide one third of these amounts. Additional resources would be required for basic health infrastructure development, tertiary care, emergency obstetrical care, specialized HIV/AIDS prevention interventions, and the treatment and care of those living with HIV/AIDS.

Further resources would be needed for other population-related development goals in the Programme of Action. Among these are:

- universal basic education;
- the empowerment of women;
- environmental concerns;
- employment generation;
- poverty eradication.

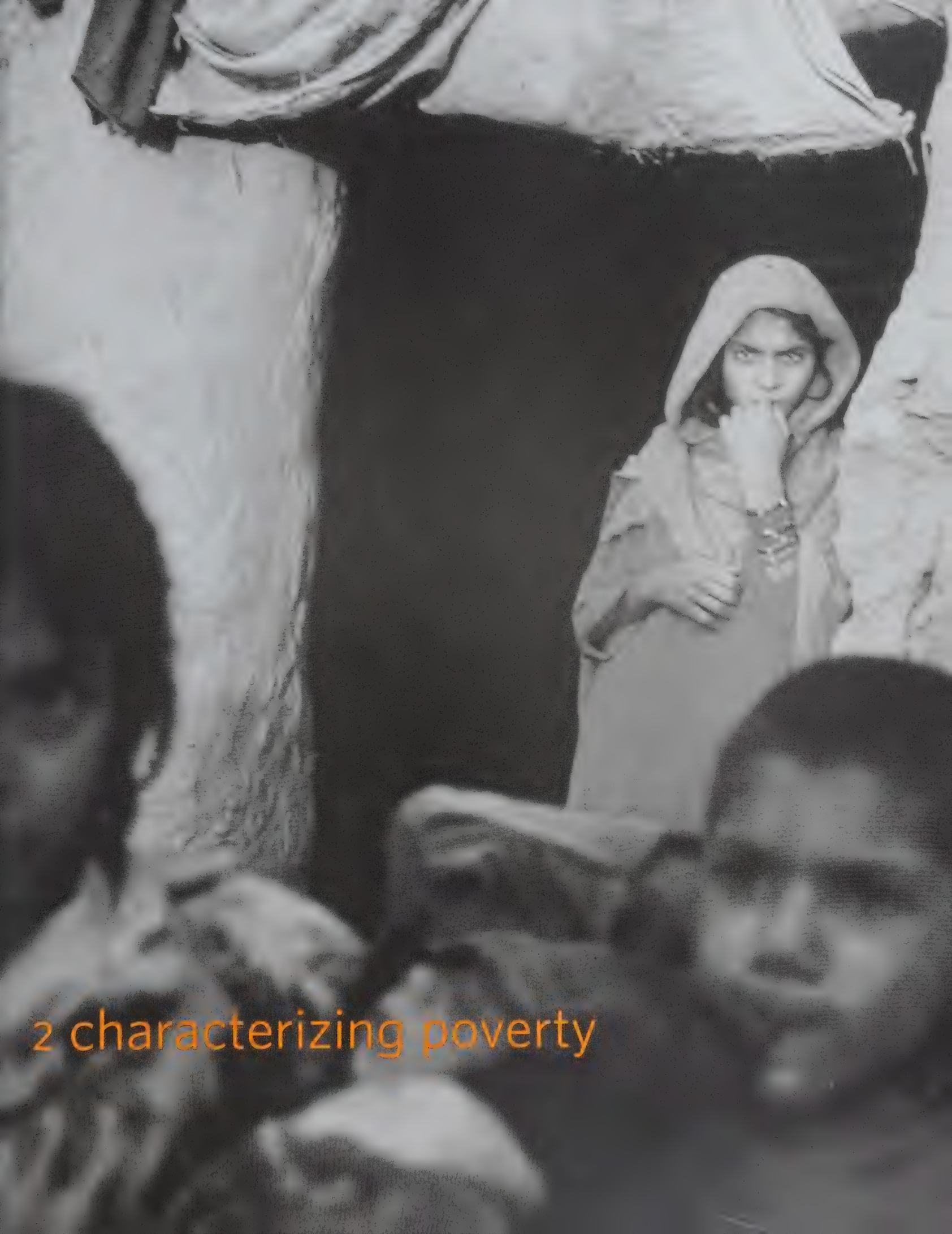
Donor countries are contributing less than a quarter of current expenditure towards the goal of universal access to reproductive health by 2015. Developing countries have contributed $8.3 billion, 76 per cent of the total and about 73 per cent of their commitment. A few large countries account for much of this expenditure.

COSTS AND BENEFITS The cost of denying health care, education and empowerment to the world's poorest people cannot only be counted in money. Gender violence alone, in the industrial countries alone, is estimated to reduce by 20 per cent the number of healthy life years experienced by women aged 15-44. The imagined economic cost, or the foregone benefits, must be multiplied by the impact on children, families and communities, over generations.

Decades of social and economic research show that reproductive health programmes, including family planning, are among the most cost-effective health and social development programmes. Education offers unquestionable benefits, especially for women. Moves towards the empowerment of women and gender equality have enriched the lives and increased the contribution of countless women.

Universal access to reproductive health care, universal education, and women's empowerment are development goals in their own right, but they are also conditions for ending poverty, closing the gaps between richer and poorer in the world, and creating a global society that is both stable and just.

Recommendations and resources are discussed in Chapter 8.



2 characterizing poverty

POVERTY OF DIFFERENT KINDS Income is the common way of measuring poverty, but poverty has many dimensions. The poor are deprived of services, resources and opportunities as well as money. Their limited resources are inefficiently deployed. Energy, water, and food all cost more per unit consumed—paradoxically, poverty is expensive for the poor.

People's health, education, gender relations and degree of social inclusion all promote or diminish their well-being and help to determine the prevalence of poverty. Escaping poverty depends on improving personal capacities and increasing access to a variety of resources, institutions and support mechanisms.

Economic growth will not by itself end poverty. The assumptions that wealth will "trickle down" to the poor, or that "a rising tide lifts all boats" are convenient, but do not always correspond to experience, especially in the poorest countries and among the poorest people. Ending extreme poverty calls for commitment to the task, and specific action directed to it.

INCOME POVERTY The global economy has grown steadily over the past three decades, but broad improvements can mask important differences from region to region, from country to country, or within countries. A large share of estimated global reductions in poverty, for example, is the result of economic growth in China. Income poverty persists, and in many places is deepening.

Based on expenditure measures, the proportion of the population in developing countries living on less than $1 a day decreased from 28.3 per cent in 1987 to 23.4 per cent in 1998. The percentages reflect population growth; absolute numbers have remained relatively stable at about 1.2 billion.

The reduction has been uneven across regions (Table 1). The most dramatic reductions have taken place in East Asia, mainly China. The most dramatic increase has been in Eastern Europe and Central Asia. There were net additions to the number of poor in both South Asia and Africa. Modest gains in poverty reduction were made in the Middle East and Latin America.

Table 1: Population living on less than a dollar a day
(at 1993 purchasing power parity)

	1987		1998	
	%	millions	%	millions
E. Asia	26.6	417.5	[illegible]	[illegible]
E. Europe / Central Asia	0.2	1.1	[illegible]	[illegible]
Latin Amer. / Caribbean	15.3	63.7	[illegible]	[illegible]
Middle East / N. Africa	4.3	9.3	[illegible]	[illegible]
S. Asia	44.9	474.4	[illegible]	[illegible]
Sub-Saharan Africa	46.6	217.2	[illegible]	[illegible]

Source: World Bank

The concept of income poverty has recently been extended to include economic vulnerability, describing households or individuals pushed into permanent poverty by temporary spells of unemployment, ill health or other misfortune.

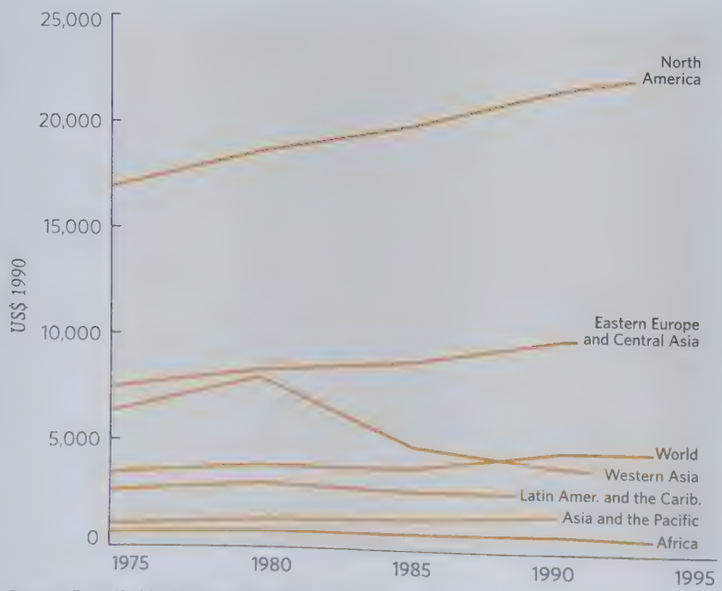
INCOME INEQUALITY Apart from considerations of human rights, justice and equity, inequality within and among nations contributes to political unrest and drives migration in search of more favourable conditions.[1] It also affects general levels of health. Life expectancies are lower in societies with greater inequality. Both the level of available resources and the equity of their distribution contribute to a society's health.

By most measures the gap between rich and poor, globally and within countries, has been growing.[2] The difference in per capita income between the world's wealthiest 20 per cent and the poorest 20 per cent was 30 to 1 in 1960; this ratio jumped to 78 to 1 in 1994, and decreased slightly to 74 to 1 in 1999.[3]

FURTHER DIMENSIONS There is a distinction between lack of income and lack of capacity.[4] Poor people acutely feel their powerlessness and insecurity, their vulnerability and lack of dignity. Rather than taking decisions for themselves, they are subject to the decisions of others in nearly all aspects of their lives. Their lack of education or technical skills holds them back. Poor health may mean that employment is erratic and low-paid. Their very poverty excludes them from the means of escaping it. Their attempts even to supply basic needs meet persistent obstacles, economic or social, obdurate or whimsical, legal or customary. Violence is an ever-present threat, especially to women.

The poorest use what resources they have, and considerable resourcefulness, in their struggle to survive. For the poor, innovation means risk, and risk can be fatal. Helping them improve their capacities calls for imagination as well as compassion.

Figure 1: Income per capita by region, 1975-1995
(in 1990 U.S. dollars)



Source: Compiled by National Institute of Public Health and the Environment (RIVM), the Netherlands, from World Bank and UN Data.

Many Dimensions of Poverty

Some of the most important dimensions of poverty are:

POOR HEALTH Health outcomes are not always closely correlated with income levels. Life expectancy at birth in Viet Nam (67.8 years), for example, is higher than in Pakistan (59.6 years) although they have similar levels of GDP per capita.[5] In many low-income countries, rapid population growth has contributed to overcrowding, unsafe drinking water and poor sanitation, ideal conditions for breeding and communicating infectious diseases. Poor communities typically lack primary health facilities, essential medicines and vaccinations.

The combination of poor general health and high prevalence of disease can extend even to the highest income groups. Figure 2 shows that child mortality rates in Pakistan and Viet Nam are significantly high even for the richest income groups. In Brazil, on the other hand, rates are significantly lower for the richest quintile than for the poorest.

Poor health is a cause as well as an effect of income poverty. It diminishes personal capacity, lowers productivity and reduces earnings. The effect of ill health on productivity and earnings is likely to be greater on the poor. This is because, among other things, low-paid, less-educated workers are more likely to do physically demanding and often unsafe work in which they can easily be replaced.[6]

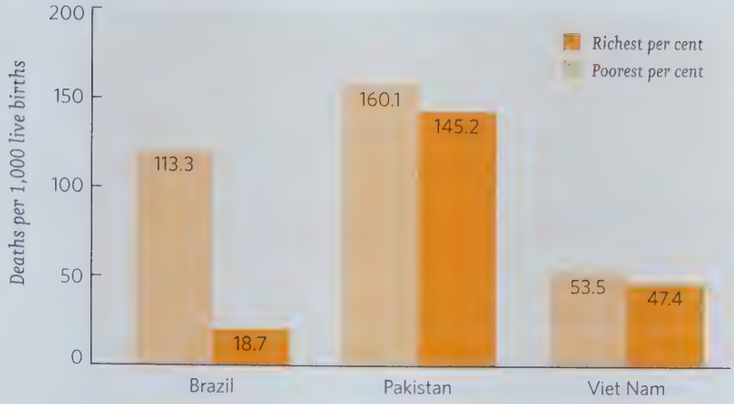
High prevalence of disease in a country goes hand in hand with poor economic performance. In countries where a high proportion of the population is at risk of severe malaria, average income is less than one fifth that of non-malarial countries.[7]

On the other hand, higher life expectancy, a key indicator of health status, stimulates economic growth: an analysis of data for 53 countries between 1965 and 1990 found that higher adult survival rates were responsible for about 8 per cent of total growth. Research showed how this works: a healthier workforce and less absenteeism improves productivity; as life expectancy increases, individuals and firms have an incentive to invest in human and physical capital; and as workers have an incentive to save for retirement, savings rates increase.[8]

ILLITERACY AND INADEQUATE SCHOOLING Illiteracy holds people back even in the most basic day-to-day activities. Inadequate schooling prevents them taking advantage of new opportunities, for example, jobs in the emerging knowledge-based industries. Less-educated people often find it difficult to express themselves outside their own immediate group either in speech or writing, so they are held back from moving into the wider society.

Like other dimensions of poverty, education and health outcomes interact. It is more difficult for illiterate or less-educated people to obtain information about health care, for example, in a form they can use. Poor health and lower survival rates reduce the incentive to invest in children's education.

Figure 2: Under-5 child mortality rates
Poorest and richest quintiles, selected countries



Source: Adam Wagstaff. 2000. "Socioeconomic Inequalities in Child Mortality: Comparisons Across Nine Developing Countries." Bulletn of the World Health Organization. *78(1).*

SOCIAL EXCLUSION AND POWERLESSNESS Poverty in another form can be seen in social systems that deny some groups of people the freedom to interact as equal partners in society or assert their personal interests in the wider community. In many countries, not all of them authoritarian, this sort of exclusion prevents large numbers of people from participating in the development process. The bias may come from caste, ethnicity or religion, or it may serve the interests of corrupt elites.

GENDER-BASED POVERTY In many societies, material poverty interacts with gender-based discrimination, so that poor women's levels of health, education and social participation are even lower than their male counterparts'. (Chapter 5 has more detail on gender and poverty.)

A Web of Causes

Recognition of the varied causes and outcomes of poverty and how they interact with each other influences the way we measure and monitor poverty and the plans we make to eliminate it. The new view of the development process—and who is left out of it—includes quality of governance and the rule of law, corruption and crime, cultural and historical factors. Only a few years ago such elements were considered to be quite outside the development mainstream and perhaps an intrusion in the affairs of sovereign nations.

In contrast, the *Human Development Report 2000*[9] of the United Nations Development Programme (UNDP) is devoted largely to the human rights record of the world's nations. UNDP's Human Development Index regularly assesses countries' progress in education and health. The World Bank has made listening and responding to the "voices of the poor" a high corporate priority.[10]

WORKING THROUGH THE DEMOGRAPHIC TRANSITION The "population explosion" that began in the 1950s was the result of a sharp fall in death rates, made possible by innovations in health care and extensive use of imported medical technology on the part of developing countries.[11] But in the poorest countries

5 **VOICES OF THE OLDER POOR IN SOUTH AFRICA AND INDIA** A recent study by UNFPA asked older poor women and men in South Africa and India, mostly in rural areas, about key issues affecting their lives. It found that many are concerned about extreme poverty: poor living conditions; inadequate health care and social protection; and inter-generational violence and abuse.

Almost 5 per cent of South Africa's population is 65 or older. These persons have lived through the indignity of apartheid and its legacy is still with them. Most are still caught in the grip of severe poverty and social exclusion.

Older South Africans identified their priority needs as: food security; clean water; adequate shelter; electricity; money and a pension; adequate health care facilities; identity documents such as birth certificates to claim their rights; and support in caring for a spouse. Their concerns with growing older centred on a fear of isolation, exclusion, abuse, illness, a sense of helplessness and the growing impact of HIV/AIDS.

India's older population is expected to grow from 77 million in 2000 to about 141 million by 2020. More than half of all older persons are on the verge of poverty, with many in poor health and living in unhygienic conditions.

Very few are covered by any kind of retirement scheme; the primary source of care and support is the family. However, economic development and widespread migration of young adults are disrupting traditional support for older people. Older women, especially those unmarried or widowed, are particularly disadvantaged.

Said Raji, 75, "I have lived alone since my husband's death seven years ago. My children migrated. They have never bothered to inquire about me. I have no income and hardly any contact with anyone. I will die like this. I have no life and am lonely and frail."

the corresponding changes that would help produce a decline in fertility—adaptation in human skills, capabilities and behaviour, improvements in physical infrastructure and technology—have been slow to follow. This mismatch has slowed economic and social progress. Imbalance between rapidly growing populations and resources to sustain them has stretched the limits of social organization, and put pressure on the institutions that serve the poor.

At the household level, high fertility increases the "dependency burden" represented by children, and reduces family well-being among the poor. Ironically, circumstances making for high fertility often coincide with expanding economic and social opportunities.[12]

As countries go through the demographic transition and fertility falls, a temporary window of opportunity opens in which families with some resources can afford to educate their children, find good jobs and accumulate some assets. But the poor, the last group in society to experience fertility decline, are unable to take advantage of the opportunity.[13] They not only have more children but also lack both information and the resources to make use of it. Their inability to respond to changed signals about the costs and benefits of children makes them worse off.

Reducing fertility helps to reduce poverty over the longer term. Demographic changes in Brazil in the last 50 years were equivalent to an additional 0.4 to 0.5 per cent in the annual growth of per capita income.[14] During this period, the average growth rate in per capita income was close to 3.0 per cent per year. The estimated direct impact of the demographic transition on poverty was close to 15 per cent of the impact of economic growth.

THE 'ENABLING ENVIRONMENT' Technological progress and accumulation of human and physical capital have been the twin workhorses of modern economic growth. But they work most effectively in an environment that provides inducements for investing. This enabling environment includes the entire social framework: a representative political process untainted by corruption; respect for human rights; equitable laws and regulations, impartially enforced; and an array of public, civil, community and cultural institutions that reinforce each other in providing fair and equal social and economic opportunity to all citizens.

A successful example is micro-finance institutions, which use small loans to multiply the impact of community resources and initiatives. At the same time as offering economic support, they encourage community-based programmes in health, education and leadership training for women. This "bundling" of services based on partnerships with local communities has changed attitudes about empowering poor women while increasing their economic power.[15]

Institutions are the social mechanisms that connect capacities and resources; the quality of institutions determines how productively or equitably the connection operates. Each element energizes—or holds back—the others. Basic literacy programmes, for example, increase individual capacity to acquire and use information about health, markets or community life; but they also improve the institutions that provide these services, putting them in a better position to connect newly literate people with useful information.

More responsive institutions likewise interact with capacity and resources: improvements in governance increase capacity by removing legal disabilities or enacting new powers; more equitable

6 **GROUP-BASED CREDIT IN BANGLADESH** The Grameen Bank in Bangladesh provides small loans to poor families to start new businesses and, perhaps, a new life, but the families first need basic literacy, family planning, and enterprise management services. Providing all this to women who have been traditionally excluded from society is a challenge. Grameen therefore provides loans to groups rather than individuals. The group approach lowers the cost of providing services, while providing mutual support that allows women to interact with the market and community at large

regulations can reduce the cost of conducting business or lower the barriers between poor people and resources. Civil society plays an important part in developing responsive institutions, for example, microcredit organizations that make resources available to the poorest groups, especially women, and at the same time offer help with literacy and support for family planning.

Many developing countries have made significant progress in improving the capacities of their populations overall: life expectancies (an indicator of health), nutrition, economic and educational attainment have all improved since 1960. But progress has been easier and faster in countries that have:

- made available the information and means for women to space and time births, and avoid pregnancy if they wish to do so;
- provided services for healthy pregnancies and safe deliveries;
- increased the coverage and quality of education systems;
- advanced gender equality and equity in other ways, such as protecting women's legal and customary rights;
- adopted population policies based on human rights;
- developed responsible and accountable systems of governance and popular participation.

Measuring Poverty

There are three commonly used methods of assessing poverty:

- construction of a poverty line and computation of various poverty measures that take into account the way actual household expenditures fall short of the poverty line;[16]
- rapid assessment and participatory appraisal, in which community members rank households by wealth;[17]
- construction of a poverty index using a range of qualitative and quantitative indicators.[18]

POVERTY LINE BASED ON HOUSEHOLD EXPENDITURES

Standard practice is to use total expenditure as the primary measure of a household's standard of living.[19] Nationally representative household surveys such as the World Bank's Living Standard Measurement Survey are typically used to fix a poverty line and measure the incidence of poverty.

To assess whether household income is sufficient to meet the food and other basic needs of all household members, a basket of goods and services is constructed corresponding with local consumption patterns. The value of this basket, at local consumer prices and satisfying a pre-set level of basic needs for one person, is called the "poverty line". If the per capita income of household members is below the poverty line, the household and its members are considered poor. But the results are hard to verify and may be subject to distortion (see below).

PARTICIPATORY APPRAISAL AND RAPID ASSESSMENT These two approaches seek input from community members using similar techniques. The first calls for extensive participation by the community and is intended for the longer term; its ultimate goal is empowerment of the target group. Rapid assessments are meant to provide data for a predetermined agenda in a very short time, usually a one-day community visit.

Development programmes use both methods extensively for targeting services to poorer clients, and for the participatory design of projects,[20] but both have shortcomings.[21] Because the results depend on the subjective ratings of community members, they are difficult to verify, and it is difficult to compare results across locations or programmes in a country.[22] International comparisons are even more difficult. These approaches may find the poorest third in one village, but may not identify communities in which the poorest third of an entire region reside. Subjects' responses may be distorted by their desire to receive benefits such as access to financial services as a result of the poverty assessment. Finally, participatory assessment requires skillful communicators who will be more expensive and harder to find than enumerators who only apply a structured questionnaire.

POVERTY INDEX BASED ON A RANGE OF INDICATORS A range of indicators, for which credible information can be quickly and inexpensively obtained, can identify different dimensions of poverty. The indicators may be aggregated into a single index by using a weighting scheme.

Many micro-finance institutions in South and South-east Asia use a housing index to target financial services to poorer clients.[23] Indicators, such as quality of roof or walls, can easily be obtained through inspection, and misrepresentation in responses can be minimized. The indicators can be easily adjusted to local conditions. The weights assigned to the different indicators making up the index may be rather arbitrary, however. And the housing index focuses on a single dimension of poverty. To provide a full picture, indicators should be drawn from at least four areas: human resources, housing, food security and household assets.[24]

CONCLUSION Income-based measures of poverty are objective, highly amenable to quantitative analysis, and accurately describe income poverty, provided household surveys are carefully administered. However, they omit non-income factors in poverty, such as achievements in health and education. They are also externally imposed and do not provide the poor an opportunity to express their own experience of poverty.

Indicator-based and participatory approaches provide some alternatives. UNDP's Human Poverty Index (HPI),[25] for example, combines information on deprivation in: longevity (percentage of people not expected to survive to age 40); knowledge (percentage of adults who are illiterate); and living standards (a composite index of people without access to safe water, people without access to health services, and underweight children under 5). This aggregate poverty measure describes several dimensions of poverty, but the assignment of equal weights to the different components is essentially an arbitrary decision.

Another approach is to elicit information directly from the poor through group discussion and individual conversation, without using any externally imposed definition of poverty. Respondents may be asked to explain their own notions of poverty, providing information on social and economic processes that standard household survey data cannot provide, which can be used to make policy, investment or regulatory decisions.

In the end, a judicious combination of income-based, indicator-based and participatory-based information should be used to assess poverty and derive implications for policy. And institutions should have incentives to use this information for planning purposes.

7 **MERITS AND LIMITATIONS OF THE INCOME-BASED POVERTY MEASURE**

Merits

Tractable definition. The method allows for a relatively tractable definition of poverty and the use of explicit poverty lines to delineate the poor from the rest of the population.

Precise, representative, comparable. Carefully conducted household surveys provide a fairly precise and widely accepted tool for measuring income poverty and assessing changes over time.

Basing income poverty assessments on representative sample surveys also makes it easy to derive aggregate measures of poverty, such as the percentage of poor in the national population.

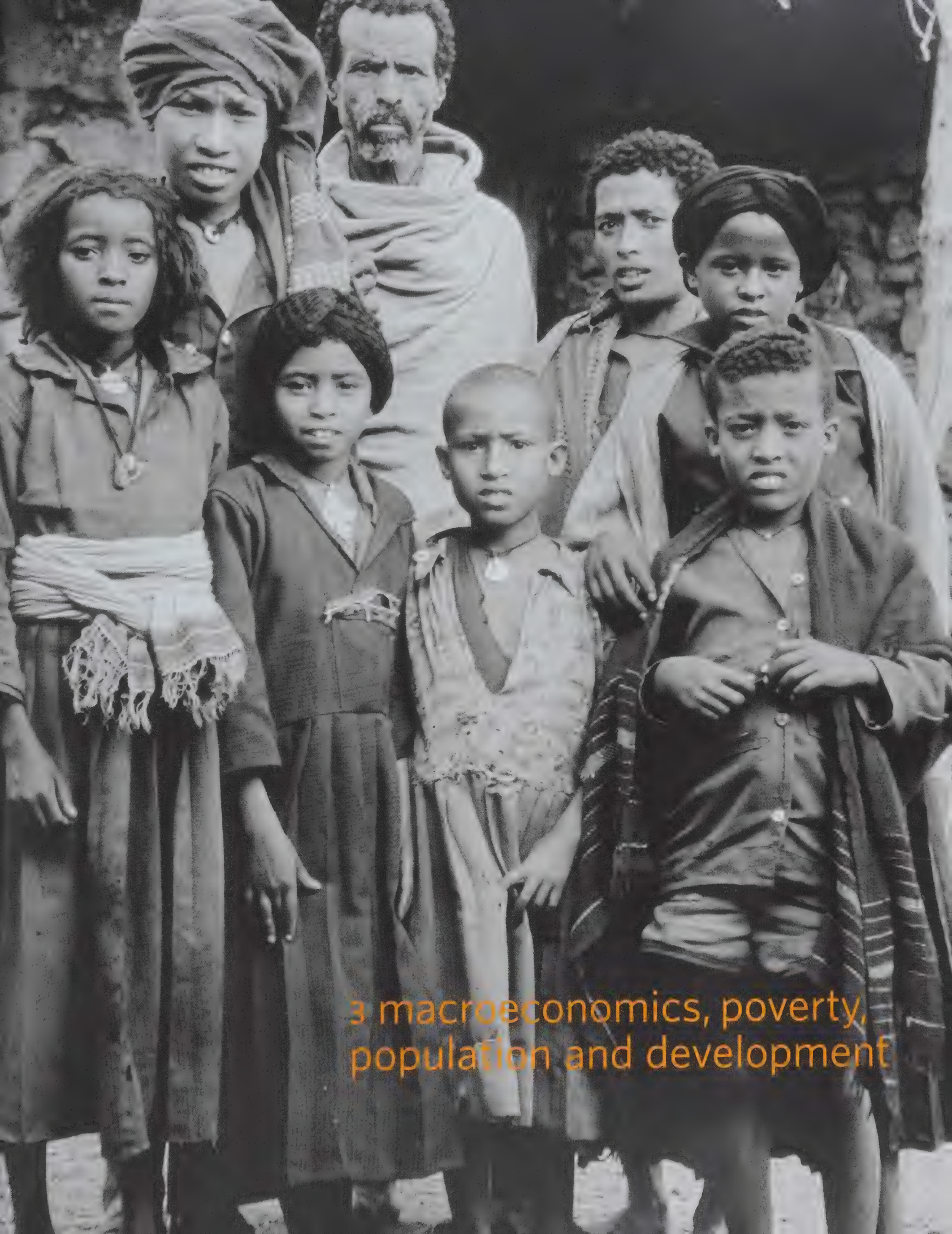
Limitations

Cost. Large household surveys are expensive. Good surveys spend heavily to ensure that information is accurate, because measurement errors can easily throw estimates off.

Household composition. Surveys convert household data into measures for individuals on a per capita basis, so results depend on assumptions about household composition and shed no light on gender-based and other inequities within the household.

Publicly provided goods and services. Household income measures typically fail to account for public goods and services like essential education and primary health.

Comparison difficulties. When survey instruments, definitions, or sampling techniques change over time, comparisons are difficult and potentially misleading.



3 macroeconomics, poverty, population and development

The Demographic Window

There is solid evidence, based on two generations of experience and research, that there is a "population effect" on economic growth. Since 1970, developing countries with lower fertility and slower population growth have seen higher productivity, more savings and more productive investment. They have registered faster economic growth.

Investments in health (including reproductive health) and education needs, and reducing gender inequality, have contributed to this effect. These investments attack poverty directly. They empower individuals, especially women. They enable choice.

Given a real choice, poor people in developing countries have smaller families than their parents did. This downturn in fertility at the "micro" level translates within a generation into potential economic growth at the "macro" level, in the form of a large group of working-age people supporting relatively fewer older and younger dependents.

This demographic window opens only once. Several countries in East Asia and a few others have taken advantage of it. The effect of declining fertility in Brazil has been equal to economic growth of 0.7 per cent of GDP per capita each year.[1] Mexico and other countries in Latin America have registered similar effects.

Countries that have ignored the potential benefit have done less well. They have not made the necessary direct investments in poor people. They lack the good governance and social accountability that ensures that some of the benefits of economic growth go directly to the poor and towards alleviating poverty. The demographic window will close within a generation, as populations age, and with it a historic opportunity.

It will be a long time before the demographic window opens for the poorest countries, but work towards it now will safeguard the future. It will also protect the present. Pregnancy and childbirth are heavy risks for poor women. Many, and unplanned for, children impose a heavy burden on them. High levels of fertility contribute directly to poverty, reducing women's opportunities, diluting expenditure on children's education and health, precluding savings and increasing vulnerability and insecurity.

Additionally, the poor suffer from the direct effects of their numbers: lower wage rates for large pools of unskilled workers, landholdings divided among more inheritors, classes too crowded for educational improvements. High fertility means that poor people have less capacity to take advantage of opportunities to lift themselves out of poverty.

The big question for national leaders, legislators, policy experts and decision makers is whether to make the necessary changes in policy and practice in the next decade; and whether the international community will make the necessary efforts to help them succeed. If they do, women and men will be healthier and better educated. They will have access, among other things, to a full range of reproductive health information and services. Fertility and population growth will fall. The demographic window will be open for the next generation. Mass poverty could become a matter of history, not a threat to the future.

LEARNING FROM EXPERIENCE Intuition tells us that rapid population growth in poor countries expands the demand for services such as health care and education faster than the capacity to satisfy it. It is equally obvious that economies need to grow in order to reduce poverty. Experience has deepened and refined both of these perceptions, and taught some lessons about how to break out of the vicious circle of increasing demands and overstretched resources.

Evidence supports the perception that large families and rapidly growing populations hold back development.

First, in the household, children have a variety of needs, all of which have a cost. A large number of children compete for limited family resources for food and clothing, health and education, and some are left behind. In rural communities, farmland is a fixed resource. Dividing it too often impoverishes successive generations. Without resources for development, supplies of fuel or water must also be shared among growing numbers. In urban communities, those without some education can find only low-level, ill-paid work, if they can find work at all. Most countries officially frown on child labour, though implementation varies, and it is becoming socially and politically unacceptable from a human-rights perspective.

Second, at the national level, rapidly growing numbers of relatively unskilled workers force down wage rates and reduce savings. Spending on health care, education and other services for large numbers of children further reduces savings. Since economic growth comes from investment, and funds for investment from savings, rapid population growth acts as a brake, not a spur.[2]

The chances for development are greatly improved if external resources are available to invest in health and education, support innovation, and find ways for people to build their savings. Countries also need to generate and redirect domestic resources for health and education.

UNDERSTANDING THE RELATIONSHIP The impact of population growth on economic development has been debated along these lines for decades. With hindsight, we can see that many positions were based on poorly framed questions and inadequate responses.

Much of the research questioned whether population growth restricted, promoted or had no overall effect on economic growth. Another debate asked whether economic growth was a precondition or consequence of slower demographic growth.

Both arguments revolved around aggregate growth in population and the economy, but the chances for economic development and poverty alleviation do not depend only on aggregates. Data on over four decades of economic and demographic change provide new insights into how development prospects are shaped.[3]

In 1986 a study on relationships between population and development from the National Research Council in the United States concluded that, despite its important effects at the household level, population growth had no effect on overall economic growth.[4]

This seemed to settle an old argument. But the council's study did not have all the evidence. It used data from the 1960s and 1970s, when many countries were still relatively early in the

"demographic transition" from high to low birth and death rates, and when centralized planning prevented some countries from making the most of increasingly favourable population dynamics. The study continued to rely on analyses of aggregate growth, both in population and economic development.

BETTER DATA, BETTER ASSUMPTIONS In the 1990s the scientific community looked at the question again. By this time it was possible to use data from longer periods, during which the demographic transition progressed in many countries. This time the conclusion was different. More important, researchers recognized that the demographic transition was reflected in changes in the age structure of populations—as life expectancy increased and fertility declined—not just in decreasing aggregate growth rates.

TAKING ADVANTAGE OF THE OPPORTUNITY The change from high to low mortality and fertility can create a "demographic bonus" for countries. Mortality declines first, followed by fertility. What happens as fertility declines is that the working-age population increases relative to younger and older dependents. That creates a one-time opportunity for growth. The opportunity can be realized if countries have made the appropriate investments, not only in family planning, but in health and education generally, with special attention to the needs of girls and women, and in employment opportunities for the new and enabled workforce. Open and responsive governance makes these adjustments possible.

Such a combination could be seen in the "Asian tigers" of the 1980s and 1990s: while the proportion of their working-age populations (15-60[5]) started to increase as late as the mid-1970s, the pace of change was extremely rapid up to the early 1990s. They made the supporting adjustments of investments in health and education early in the development process, and also created a framework for more open markets and social participation.[6] The relative growth of working age populations in these countries will continue for another decade, though not as rapidly as in the past.

This is a once-only opportunity, a demographic window that opens as the numbers of younger children decrease because of lower fertility, and closes as the proportion of older people starts its rapid growth.

REGIONAL PATTERNS Many countries are entering the transition period. **South Asia** will reach its peak ratio of working-age to dependent-ages between 2015 and 2025 (though with considerable national variation). In **Latin America and the Caribbean**, the relative increase in the working-age population started at least five years earlier than East Asia, but the proportional change has been less marked, reflecting the wide disparities within countries and regions. The wealthier groups have completed the demographic transition to lower fertility and mortality, but poorer ones continue to lag. The peak proportion in working ages will be reached during the period 2020-2030, but at a slower rate and a lower level than in East Asia.

The countries of **North Africa**, and **Western Asia** and **Central Asia** are at a variety of stages in the demographic transition.[7] Some will be approaching their demographic opportunity within two decades, while others are over a generation away. These countries have an opportunity to establish within one generation the frameworks for accelerated social change and economic growth.

The demographic window in **Oceania** is narrower. Fertility was never as high, nor did it drop so fast as in East Asia. Nevertheless, some of the same considerations apply.

In **sub-Saharan Africa** the median age of the population of the entire region is only 17.6—that is, half the population is below that age. Meanwhile, the working-age proportion of the population between 15 and 60 (50.9 per cent) is lower than it was in 1950 (52.5 per cent). Poverty imposes severe handicaps—severe resource constraints, underdeveloped health infrastructure, social instability, high debt, weak governance and the HIV/AIDS pandemic. Nevertheless, a growing number of countries are beginning their demographic transition. Continued progress will depend on the availability of reproductive health services including family planning.

8 **DEMOGRAPHIC SCENARIOS** The global demographic situation and future implications are increasingly varied. Fertility in developing regions has been cut in half (from 6 children per woman to 2.9) since 1960. Contraceptive prevalence has increased from 10 to 62 per cent of women, and life expectancy has increased from 48 to 64 years. In the least-developed countries, fertility has declined only to 5.2, from 6.6, and life expectancy increased to just over 50 years from roughly 39.

Projections are not forecasts: they depend on assumptions about fertility, mortality and migration—and assumptions are adjusted to changing circumstances.

The projections of the United Nations Population Division have been strikingly accurate, even over relatively long periods. They suggest that global population will increase to 9.3 billion by 2050. Belying suggestions of a global "birth dearth", the less-developed regions will add 3.2 billion (going from 4.9 to 8.1 billion) by 2050—the same number as were added between 1950 (when there were only 1.7 billion) and 2000.

In 2001 and 2002 the Population Division held a series of expert discussions on fertility and mortality change, and the demographic futures they imply. Two meetings addressed different assumptions, the first in countries where fertility is already low, the second in persistent high-fertility countries. Experts suggested that earlier projections of declines from high fertility might have been overly optimistic.

A third consultation looked at intermediate-fertility countries (those with between two and five children per woman) and concluded that these countries might stabilize somewhat below the replacement level of 2.1 children per woman. They also recognized that the pace of fertility decline often becomes very gradual. The prospects for each country would have to be assessed and updated regularly.

The consultations emphasized that future fertility decline depends on preventing unwanted fertility and on continued investments to strengthen family planning and reproductive health efforts.

Only six of the 46 sub-Saharan African countries have populations with median ages as high as 20 years (the median age in more-developed regions is now around 36). By 2050, the regional median age will reach 26.4, lower than more-developed regions a century earlier. The working-age population will increase to 62.2 per cent by 2050. Only 11 countries are projected to reach their maximum working-age proportion prior to 2050 (and eight of these will do so between 2040 and 2050).

FUTURE PROSPECTS Even beyond the 15-year horizon of the Millennium Development Goals, population trends will affect the prospects for a sustained attack on poverty. Population momentum and high levels of unwanted fertility threaten economic gains already made. Pervasive gender inequality could undermine the goal of universal access to reproductive health services.

The HIV/AIDS pandemic further imperils the chance for many of the poorest countries to consolidate their gains and open the "demographic window". The growth of working-age populations relative to young dependent populations is crippled by rapid growth in adult deaths. The disease both devastates the present and steals the future.

SPENDING THE BONUS The "demographic window" opens only once, and for a limited time. Most industrial countries have already settled into a pattern of gradually increasing life expectancy and continued sub-replacement fertility. In these countries, the imminent prospect of population declines and rapid growth in older age groups are already stimulating intense discussion. The debate ranges far from demographics and has touched on race relations, welfare policies, and the state of marital relations in two-income families.[8]

Some observers suggest that immigration is part of the answer, and immediately tap into emotional issues about national identity and social tensions among "ethnically different" groups. Others raise questions about financing old-age pensions and health care for the very old, but they often underestimate the variety of possible adjustments and reforms, or the time available in which to make them.[9]

Changes in the proportion of older people may have less economic impact than fluctuations in younger age groups.[10] It cannot be assumed that the elderly (except the "oldest old") are dependent and a burden on the economy. Continuing economic activity among the elderly, personal savings, family support and public programmes may combine to form new markets and changing demand for goods and services. They can also supplement pension and health system adjustments.

On balance, the effect on economic growth might be positive.[11] But both developing and industrial countries need to understand how long-term demographic change works; they must base their policy on rational expectations rather than emotional responses.

Fertility Decline and Economic Growth

Half of the improvement in economic growth attributable to population has come from cashing in the demographic bonus, the other half from shifting economic consumption towards the poor.[12] Many mechanisms contribute to this effect: for example, lower fertility increases women's participation in the labour force and helps improve family health and nutrition. Smaller family sizes reduce dependency ratios within families and increase incentives to acquire income beyond the basic necessities of life.

Long-term demographic and economic data from 45 developing countries show that high fertility increases poverty by slowing economic growth and by skewing the distribution of consumption against the poor. Reducing fertility—by reducing mortality, increasing education and improving access to services, especially reproductive health and family planning—counters both of these effects. The national effects on poverty reduction are clear from both average GDP increase and consumption figures.

The average poverty incidence in 1980 was 18.9 per cent, about one in every five people. Had all countries reduced net fertility by five births per thousand women of reproductive age during the 1980s (as many Asian countries did), poverty incidence would have been reduced by a third, to 12.6 per cent, or one in eight.

9 **MEETING THE NEEDS OF THE ELDERLY POOR** Poverty is the main threat to the well-being of older persons. Many of the 400 million people over age 65 in developing countries live below the poverty line. To meet the Millennium Development Goal of halving the proportion of people living in extreme poverty by 2015, poverty reduction strategies must focus on the poorest and most vulnerable older persons, especially women, and on breaking the poverty cycle that runs from one generation to the next.

The experience of poverty in childhood and adulthood deepens with age. People who have endured a lifetime of poor diet, multiple pregnancies, inadequate reproductive health care and arduous physical labour are likely to enter old age in ill health. The inevitable physical decline brought on by ageing reduces each person's ability to contribute to the household and to remain economically self-sufficient.

Population ageing is an inevitable consequence of the shift from high to low birth and death rates, which is occurring much faster in developing countries than was the case with developed countries.

An effective response to older people's needs, expectations and rights requires action to:

- provide adequate health services for older persons;
- eliminate violence against older women and men;
- support the care-giving services older persons provide, especially women's care for grandchildren orphaned by HIV/AIDS;
- strengthen social protection schemes, and ensure that older persons are provided with appropriate social services;
- support research on population ageing, especially its gender and sociocultural aspects and its implications.

Guided by the ICPD Programme of Action and the Millennium Development Goals, UNFPA advocates for mainstreaming ageing issues into the development agenda, with a particular focus on the needs of the older poor and the excluded, especially women.

Country studies reinforce the conclusion. In Brazil, 25 per cent of those born in 1970 are poor. If fertility levels had stayed as high as they were early in the century, this would have been 37 per cent. The reduction in poverty is equivalent to what would be gained from a 0.7 per cent annual increase in per capita GDP.[13]

FEWER EXPENSES, MORE OPPORTUNITIES The positive redistribution effect comes first, from slower growth in outlays on children's basic needs and education, and second, from more opportunities for poor households to increase their labour contribution, income and savings. Growing consumption across the board helps poor households because it increases demand for labour, which raises wage rates—even for families whose own fertility does not decline. Slower growth in the rural labour force lowers demand for land (reducing the cost and slowing the unsustainable fragmentation of holdings).

About half the estimated decline in poverty comes from increases in economic growth and half from the consumption side. The impacts can be considerable. A fall of 4 per thousand in the net birth rate, for example, would translate into a 2.4 per cent decline in those living in absolute poverty in the next decade.

DIFFERENT STAGES OF THE TRANSITION The effects vary at different stages in the transition from high to low fertility and mortality. At first, when mortality declines and more infants and children survive, expenditure on childhood needs increases and economic growth slows. As fertility declines and population growth slows, economic growth increases.

In the early stages of transition the gap between poor and other households may actually widen, because fertility decline starts among the better off and they reap the greatest benefit from it. As poorer families join in the transition (which has been slow to happen in many parts of the world) poverty and inequality start to decrease.

Increasing inequality in the early stages of the demographic transition has a particular effect on those near poverty. It takes just a small decrease in resources or increase in needs to push them over the line into poverty.[14] High fertility, moreover, appears to have a greater impact on the depth than on the frequency of poverty.[15]

The poorer the country, and the higher fertility is when it starts to decline, the greater the contribution of reducing fertility to reducing poverty. The beneficial effects increase as the demographic transition proceeds. The faster the fertility decline, the larger the potential benefits of the demographic bonus, but the shorter the time available to take advantage of it.

SUPPORTING FACTORS Demographic changes interact with markets, institutions and government policy. The impact of fertility declines on poverty will be stronger where labour markets and school systems are working well and parents are prepared to invest in their children's education.

Economic and social policies matter. Combined with access to reproductive health information and services, they can accelerate poverty reduction.

Changing opportunities for women reinforce the effects of the demographic bonus as the age structure changes. Female labour force participation also contributes to economic growth, particularly when wages are fair and declining fertility is linked to increased women's employment.

Rising levels of women's education and increased demand for labour by a growing formal sector increase the "opportunity cost" of high fertility—women lose income and other opportunities by having more children. Higher education levels and fertility declines can combine in a positive feedback in which the labour force increases faster than the growth of the working-age population.

EFFECTS OF DEMOGRAPHIC TRANSITION ON THE POOR The effects of the demographic transition vary for different groups. Poorer couples, acting according to their perceptions of their best strategies for survival and success, start their families earlier, have more and more closely spaced children and over-compensate for high child mortality.

FAMILY SIZE NORMS Family size and family welfare relationships are not only matters of individual choice and behaviour. Choices are affected by social norms, patterns of gender relations, public policies and institutions.

In the past, large families were the norm. Once a woman was married, her fertility was not a matter of choice. A woman who had many sons was honoured and secure: sons (and to a lesser extent daughters) were perceived to be a blessing. They were needed for their economic or household contributions, to give assistance in old age, and for performance of cultural practices. Today, such rationales are losing force.

Larger families drain poor people's capacity to provide for children. Whatever economies of scale they provide—sharing living space or handing down clothes, for example—are outweighed by increased expenditures and competition for scarce resources. (Over 70 per cent of consumption income for families near the poverty line is devoted to food.[16]) As governments seek to collect fees and revenues for a range of services, including education, health and transport, the disadvantages increase.

The poor lack education in general and education about health in particular. They also lack access to treatment for illness and funds for care. Poor populations begin mortality decline later than their wealthier counterparts. Their incentive to reduce fertility lags even further.

These delays impose further burdens on the poor. There is a higher risk of malnutrition associated with birth intervals of less than two years in households with little property. Losses to health and education are considerable.[17]

MISSED OPPORTUNITIES With better health care, better and more accessible services, more education and wider choices for women, millions of people in many countries have opted for smaller families.

The poorest have missed these opportunities. They do not get the information or support that would allow them to recognize the changes that favour smaller family sizes and larger investments in the health and education of fewer children.[18] As a result, they expect benefits that large families no longer provide—returns from child labour, for example. They still see a need for the "insurance effect" large families used to provide, although today's children are

10 SUPPORTING POVERTY ALLEVIATION IN MEXICO UNFPA's most recent country programme in Mexico focused on five of the poorest states: Chiapas, Guerrero, Hidalgo, Oaxaca and Puebla. Several innovative projects linked poverty alleviation to reproductive health.

In Chiapas, health promoters and midwives were trained to provide and promote the use of quality reproductive health services. Educational materials were developed to address reproductive rights, gender equity, sexuality, family violence and sexual and reproductive health. Indigenous women were helped with childcare and nutrition. Men were also encouraged to participate in improving reproductive health.

In seven poor, rural regions and 42 municipalities with largely indigenous populations, reproductive health services were enhanced, and community health assistants were trained to provide health education to adolescents. Young people were involved in efforts to strengthen links between service providers and the communities, and support was provided to an institution that works to help rural youth overcome cultural and linguistic barriers. The project also facilitated exchanges of experience among rural midwives.

Safe motherhood was promoted in five Chiapas municipalities by training traditional midwives, and through radio programmes in local indigenous languages.

Reproductive health services in four marginal urban areas and 18 rural areas in Hidalgo were expanded by setting up itinerant health brigades; medical personnel and community health workers received training, and a system for evaluating service quality was established. In Oaxaca training efforts focused on safe motherhood and gender equity for female migrants, particularly agricultural workers.

In addition, UNFPA provided technical support to population planning institutions in five high-priority states to advance the national poverty alleviation strategy, helping them improve local capacity to select the best locales for programmes. This successful initiative encouraged the government to mobilize domestic and donor resources to expand these efforts.

much more likely to survive until their parents are elderly.

Women and girls in poor families who have little part in decision-making and resource allocation bear the higher costs of high fertility, but they do not benefit from the immediate gains when fertility falls. They are less likely to challenge the conditions that restrict their access to reproductive health information and services.

The poor need investments that strengthen services and institutions and increase opportunity for all, particularly for women. These investments will promote better health, allow parents to have the number of children they wish, encourage further declines in desired fertility and enable better education and life choices. The process will hasten the accumulation of the "human capital" needed for accelerated and sustainable development. The challenge is to ensure that the poor are included in these opportunities.

Globalization and Poverty

Globalization should be an opportunity for the poor, but it often does not work that way. Globalization opens markets, but markets can confer their benefits only on those they include. The poorest are almost by definition excluded, except at the lowest level of market operations.

A wage-based market economy tends to drive up the price of essential goods and services including food, water, housing and energy, while wages at the low end do not keep pace, and the non-waged see even low-cost goods move out of their reach. "Liberalizing" the market for necessities has actually driven people into poverty, not rescued them from it. Markets are aimed at maximizing profit, not attacking poverty.

The poor provide little opportunity for profit, and find less. Globalization as currently practised can expand employment at the low end of the income scale. Sometimes it has the opposite effect: opening markets, for agricultural products, for example, has concentrated economic activity and made subsistence farming uneconomic.

Many agricultural workers have gone on to an uncertain future in the towns. This can have a disproportionate effect on women when they are a large part of the rural labour force. Globalization has opened new opportunities for women in the urban labour market, but with many risks and strict limitations on their upward mobility.

The effect of globalization can also be seen in the swift transfer of social goods—drugs and medical technologies, for example—across countries, from one affluent group to another. But by and large globalization has so far had little positive effect on health, education and other social goods for the poor. In fact the opposite is often the case.

There is considerable pressure on developing countries, in the guise of economic restructuring, to curtail public expenditure and rely on the free market. But cuts in public expenditure are frequently indiscriminate, removing support for public services like education and health care, which are used most heavily by the poor. The free market does not supply these goods to the poor, because they are not profitable.

Poor people need globalization policies that work for them. Recommendations in this area go well beyond the scope of this report, but they should include new approaches to debt, trade and economic restructuring, as well as international assistance. The UN's Financing for Development conference in 2002 pointed to important needs and strategies.

To the extent that policies in these areas make poor people poorer and increase inequality, they push back the time when the demographic window will open and economic growth and fertility decline will reinforce each other. To make the most of globalization, part of the economic gains must be ploughed back into social programmes that directly help the poor.

4 women and gender inequality

"The empowerment and autonomy of women, and the improvement of their political, social, economic and health status, constitute an important end in themselves and one that is essential for achieving sustainable development. There should be full participation and partnership of both women and men in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household."

—International Conference on Population and Development, 1994

"Equality between women and men is a matter of human rights and a condition for social justice and is also a necessary and fundamental prerequisite for equality, development and peace."

—Fourth World Conference on Women, 1995

It is seven years since the Fourth World Conference on Women noted the "feminization of poverty" and the world's nations pledged themselves to work for gender equality and social development as a means of reversing the trend. There is broad formal consensus that women as well as men have an active interest in economic and social development, and that they should take part in planning and implementing strategies for poverty eradication.

Since the Millennium Summit in 2000, concern with ending poverty has intensified in the international community and the United Nations system, but there is less systematic effort towards ending poverty among women.

More women than men live in poverty, and the disparity has increased over the past decade, particularly in developing countries. Gender disparities in health (see Chapter 5) and education (Chapter 7) are wider among the poor, and wider in poor than in other countries, though the gap has narrowed over the past 30 years.

Gender disparities persist because social and legal institutions still do not guarantee women equality in basic legal and human rights, in access to or control of land or other resources, in employment and earnings, and social and political participation. These disparities have serious consequences, not only for women themselves, but also for their families and for society at large.

One recent study reported, "Gender biases embedded in institutions, markets and economic processes remain unaddressed and are reinforced by some macroeconomic polices and development strategies. Many women, as a result, become disenfranchized and disempowered."[1]

Measuring Gender Inequality

Measuring differences in income or consumption is the usual method of gauging poverty, but the indicators are not usually collected or presented in a gender-sensitive way. Figures indicate what proportion of the population have inadequate incomes, but not how many are women and how many men.

Power, nutrition, health, and time allocation may be more important than income as indicators of differences in well-being between men and women. Some social indicators, notably adult and infant mortality rates, may differ more widely with income among females than among males.[2]

POVERTY INDICATORS Attempts to construct a gender-sensitive poverty indicator have compared the incidence of income or consumption poverty among female-headed and male-headed households.[3] It is difficult to compare these efforts because of differences in methodology, but one review showed that 38 of 61 such studies found that woman-headed households are over-represented among the poor.[4]

A more striking finding is that there are disproportionately more women living in poverty in male-headed households and fewer men living in poverty in female-headed households. Because female-headed households account for a small proportion of the population, their contribution to aggregate poverty is small compared to all females living in poverty.

This approach has many problems, since definitions of female headship, and reasons for it, vary widely.[5] One useful alternative gender-sensitive indicator is the gender-poverty ratio, the number of women per 100 men in the poorest fifth of the population or living below the poverty line. Data from the early 1990s show this ratio ranging widely, from 93 in Nepal to 130 in Bangladesh and as high as 190 in Botswana.[6]

SOCIAL INDICATORS One index of household gender inequality uses data from 40 developing countries[7] and four measures: whether the woman works for cash income; woman's age at first marriage; difference in the woman's and her partner's age; and the difference in years of education.

An index of societal gender inequality is also composed of four measures: difference in weight for age of girls and boys under five; per cent of female children out of total children under five; difference in age-adjusted vaccination score of girls and boys under five; and difference in years of education of adult men and women.

This index shows that women tend to be less educated than their husbands, the difference being greatest in South Asia and the smallest in Latin America. Women marry younger in South Asia and at older ages in Latin America. Differences in the preferred numbers of girls and boys by region are similarly largest in South Asia and smallest in Latin America. Boys are also treated most preferentially with respect to preventive health care in South Asia, suggesting that son preference may be greater in countries where women have lower status.

HUMAN RIGHTS Data from several studies on political, ethnic, and gender-based rights for more than 100 countries in 1985 and 1990[8] provide indices of human rights, with scores from 1 (consistent pattern of violation of rights) to 4 (unqualified respect for freedoms and rights). Of the 40 rights indices collected, several pertain to gender equality in rights—political and legal equality, social and economic equality, and equality in marriage and divorce proceedings.

These indices show there has been a tendency towards gender equality in rights in most regions since 1985, but that women continue to be disadvantaged relative to men in basic rights and associated status. For political and legal rights, all developing regions score between 2 (frequent violations) and 3 (occasional breaches).

II **EMPOWERING POOR WOMEN IN IRAN** UNFPA's assistance programme in Iran focuses on five of the most-deprived, hardest to reach and remote areas, with the lowest indicators in health and education: Sistan and Baluchestan, Bushehr, Golestan and Kordestan provinces; and Islamshahr in the Tehran suburbs.

The Fund is cooperating with the Centre for Women's Participation to introduce a pilot income-generation scheme for poor women in a number of villages. Through a revolving fund mechanism, women who are heads of households have received loans to engage in animal husbandry, carpet weaving, sewing and fishery.

Another initiative, a joint project with the Literacy Movement Organization, combines literacy training and skills development with reproductive health education. After completing the training, women receive seed money to start the activities for which they have been trained.

In general, there is greater gender inequality in social and economic rights than in legal and political rights, especially in South Asia and sub-Saharan Africa. The exceptions are in Eastern Europe and Central Asia, and in East Asia and the Pacific.

Finally, gender inequalities vary most across regions with respect to rights in marriage and divorce. Women in Eastern Europe and Central Asia experience the greatest relative equality and women in South Asia, sub-Saharan Africa, and the Middle East and North Africa the least.

These measures show the link between gender inequality and women's own reproductive health as well as the health and nutrition of their children. In Egypt, higher scores on decision-making and freedom of movement are associated with higher probability of using contraception,[9] and women's empowerment contributes to infant survival and complete infant immunization.

Economic Inequity

PAID AND UNPAID LABOUR In many developing countries women are responsible for agricultural production and market work as well as unpaid, non-market work. Unpaid work ranges from care for the children, the elderly and the sick to subsistence production and domestic chores, which in developing countries may include walking many miles to fetch firewood and water.[10]

Recent time-use surveys show that at least half of women's total work time is spent on unpaid work. Data from nine developing countries showed even larger differences, with women spending on average 34 per cent of their time on paid market work and 66 per cent on non-market work, compared to 76 per cent and 24 per cent, respectively, for men.[11]

In rural Nepal, men spend eight hours a day on market work and only two hours on home production, but women work 7.4 hours on market work, and five hours on home production. Women also overlap activities such as taking care of children while working in the home or in the fields.[12]

Research in 31 countries, both industrial and developing, on the amount of time women and men spend on market and non-market activities[13] shows that:

- Women work longer hours than men in nearly every country. Of the total burden of work, women account for 53 per cent in developing countries and 51 per cent in industrial countries.
- Of men's total work time in industrial countries, roughly two thirds is spent in activities that are counted towards measures of GNP and one third in unpaid activities; for women, the shares are reversed. In developing countries, more than three fourths of men's work is included in the national income accounts.
- Low-income women have longer working days than higher-income women, to the detriment of their health and nutritional status.[14]

When time spent on home production is included in the computation, women contribute 40 to 60 per cent of household income.

Non-market production by women is a crucial element in determining the quality of life and directly affects the health, development and overall well-being of children and other household members. Yet women's voices and lived experience—whether as workers (paid and unpaid), citizens, or consumers—are still largely missing from debates on finance and development.[15]

EFFECTS OF INVISIBILITY The differences in the work patterns of men and women, and the "invisibility" of unpaid work not included in national accounts, lead to lower entitlements to women than to men. This inequity in turn perpetuates gender gaps in capabilities.

For example, when girls reach adolescence they are typically expected to spend more time in household activities, while boys spend more time on farm or wage work. By the time girls and boys become adults, females generally work longer hours than males, have less experience in the labour force and earn less income.[16]

This has implications for investments in the next generation. If parents view daughters as less likely to take paid work or earn market wages, they may be less inclined to invest in their education, women's fastest route out of poverty.[17]

THE DOUBLE BURDEN More women are taking paid work in industry and services. In most developing countries a growing number of women are employers or self-employed, most of them in agriculture and in informal sector small-scale and micro-enterprises.[18] But entering the labour market can leave women poor in both time and money. They work double days, at work and at home. They often earn less than men for the same work, and have less opportunity to improve their skills.

In addition, women's unpaid labour and the need for non-marketed goods and services increases with economic shocks, such as those associated with economic restructuring or the HIV/AIDS pandemic, when governments reduce social services or when their market costs become unaffordable. Poor women do more unpaid work, work longer hours and accept degrading working conditions during these times of crisis, just to ensure that their families survive.[19]

ACCESS TO RESOURCES Women today have more opportunity to invest in and make use of "human capital", such as education and health, but there has been less progress in recent decades in securing their access to natural and physical capital such as money and land. This has high costs at both the individual and the household level.

HOUSEHOLD POWER RELATIONSHIPS Many decisions about the distribution of resources between men and women are made within families. This is not a straightforward process; it involves negotiation and the use of power, which are in turn strongly shaped by social context.

Control of resources is determined in part by what an individual brings into the household—physical assets, wages or other income, transfer payments or welfare receipts that may affect their ability to bargain. The threat of withdrawing from the household adds bargaining power, providing the threat is credible. It is a threat most commonly used by men in relation to wives, daughters and other female relatives.

Some external influences, like legal rights and community support, can increase joint decision-making. Women can also mobilize personal networks to improve their bargaining power. Membership in organizations, access to kin and other social networks, and other forms of "social capital" may add bargaining power in the household.

Many influences are intrinsic, such as knowledge of personal rights and the self-confidence to use it. Education confers a big advantage. Physical power is also an advantage.

Recent household surveys by the International Food Policy Research Institute (IFPRI) show that assets brought to marriage have an impact on bargaining power within marriage. In five developing countries studied—Bangladesh, Ethiopia, Ghana, the Philippines and South Africa—men bring more land and assets to marriage than their wives. In most of these countries, husbands also have more years of schooling than their wives.

Women's assets may nevertheless provide some independence and influence household decision-making, particularly on food, education, health and children's clothing. Even where husbands control most of the resources, as in Bangladesh, women's assets positively affect spending on children's clothing and education, and also reduce girls' rate of illness.

REDUCING GENDER INEQUALITY Programmes that reduce gender inequality can significantly improve individual and household welfare as well as national economic growth.

If sub-Saharan Africa, South Asia and West Asia had had the same female-male ratio in years of schooling that East Asia did in 1960, and had closed the gap at the rate achieved by East Asia from 1960 to 1992, their per capita income could have grown by 0.5 to 0.9 percentage points per year, a substantial increase over the actual growth rates of 0.7 per cent per year in sub-Saharan Africa, 1.7 per cent in South Asia and 2.2 per cent in West Asia.[20]

IFPRI research shows that reducing inequalities within the household by equalizing human capital, land and inputs used by women can increase crop yields by 20-25 per cent.[21] In Kenya, giving women farmers the same education and resources as men increased yields by 22 per cent.[22]

EDUCATION INITIATIVES Scholarships for girls and incentive programmes to increase girls' enrolment, such as those in Bangladesh and Mexico, motivate parents to send their daughters to school.

The programmes have had a powerful effect on income, education, nutrition, health and women's sense of empowerment. Boys' school enrolment (particularly beyond primary school) increased because they work less. Girls' secondary school enrolment increased by as much as 14 per cent.

Improving women's education also helps reduce child malnutrition. A recent study shows that increases in women's education made the greatest contribution to reducing the rate of child

12 INCOMES AND BETTER HEALTH FOR LAOTIAN WOMEN Women's economic contribution in one Laotian village is now seen to be as important as their role as mothers and wives, as a result of UNFPA assistance. Villagers now have access to reproductive health information and services, too, thanks to the efforts of the Fund and its national partners, the Lao Women's Union and the Ministry of Health.

Ban Bo Piet is a village of 54 households in one of the most inaccessible mountainous areas of the Lao People's Democratic Republic. It was settled in 1993 by a previously nomadic group that practised slash-and-burn subsistence farming. Poverty and malnutrition were prevalent. Agricultural production is slowly changing to commercial production, including rice and pig farming.

UNFPA helped start a seed fund so the community's women could begin cultivating cardamom, an environmentally friendly and productive cash crop. The village has two reproductive health volunteers, who provide information and promote services that include family planning counselling. One has just attended a gender and reproductive health course organized by the women's union with UNFPA support.

"Before I became a volunteer, no one in my village knew about family planning, gender issues or male involvement," she says. "We would marry very young, carry out all of the domestic work and have no time for ourselves or for helping in the fields, especially when we had so many children. We now know about HIV/AIDS prevention, family planning methods and where health services are located. We have also encouraged our husbands to help us at home."

"We all support the reproductive health programme because it helps us break out of the cycle of poverty," says the village chief. We understand well that better health for women is linked to smaller families and better nutrition for our children"

malnutrition, accounting for 43 per cent of the total reduction. Improvements in food availability came in a distant second, contributing 26 per cent.[23]

Closing the gender gap in education also helps women to reduce fertility and improve child survival.[24] One study found that an additional year of female education reduced total fertility by 0.23 births,[25] another that the reduction was 0.32 births.[26]

In countries where girls are only half as likely to go to school as boys, there are on average 21.1 more infant deaths per 1,000 live births than in countries with no gender gap, controlling for other factors.[27]

CREDIT AND EMPOWERMENT Part of the success of group-based credit programmes such as the Grameen Bank has been attributed to a lending and support mechanism in which the group empowers the individual woman. Effective NGOs have developed explicit empowerment objectives that go beyond economic empowerment to include legal awareness, political participation and use of contraception.

GOVERNANCE Improving gender equality also involves ensuring that women are fully represented at all levels of decision-making. Women need to be able both to participate directly in making tax, health, labour, land or budget policies and to hold policy makers accountable for their impact.

Improving gender equality can improve governance. Some reports suggest that women are less involved than men in bribery, and are less involved in bribe-taking.[28] Cross-country data from 98 countries, both high- and low-income, show that corruption, measured using a "graft index", is less severe when women hold a larger share of parliamentary seats and senior positions in the government bureaucracy, and make up a larger share of the labour force.

The most dramatic gain in women's representation occurred in South Africa, where the first election after the end of apartheid increased the proportion of women in the national Parliament from 1 per cent to 30 per cent. The resulting pressures for gender-sensitive innovations such as the Gender Budget—which analyses the different impacts government expenditure and revenue have on women and men—attest to the effects of women's participation.

HIV, Poverty and Gender Inequality

Twenty years ago, early in the HIV/AIDS epidemic, women were rarely infected. By 1997, worldwide, 41 per cent of all HIV-positive adults were women. By the end of 2001, the figure was nearly 50 per cent and in sub-Saharan Africa, 58 per cent.[29]

Policy makers now acknowledge that women are being infected because they are women. Mozambique's Prime Minister, Dr. Pascoal Mocumbi, reported in 2001 that the overall rate of infection among girls and young women in his country was twice that of boys their age: "Not because the girls are promiscuous, but because nearly three out of five are married by age 18, 40 per cent of them to much older, sexually experienced men, who may expose their wives to HIV/AIDS. Abstinence is not an option for these child brides. Those who try to negotiate condom use commonly face violence or rejection."

13 **BIAS IN CHILD NUTRITION?** Is there gender inequality in the feeding of children? The evidence is mixed. There is bias against females in South Asia (and also some parts of China) but it is diminishing. Demographic and Health Surveys in 40 developing countries do not show significantly better nutritional outcomes for boys, with the exception of Bangladesh and Nepal.

14 **PROMOTING HEALTH, NUTRITION, EDUCATION, SELF-ESTEEM** PROGRESA (*Programa Nacional de Educación, Salud y Alimentación*) has educated Mexican women on health and nutrition issues, provided new spaces in which to communicate with other woman, educated girls to improve their position in the future, and increased their self-confidence and self-esteem. The programme began in 1997 as a country-wide effort to fight extreme poverty in Mexico's rural areas.

With a budget of $500 million, PROGRESA provides monetary assistance, nutritional supplements, educational grants, and a basic health package to poor families for at least three consecutive years. One of its innovations is to provide money directly to women, putting additional resources under their control and giving them greater freedom in their own movements.

Dr. Mocumbi believes that no effective action against the pandemic is possible until leaders in sub-Saharan Africa recognize that the primary means by which AIDS is spread is risky heterosexual sex. This goes beyond a health issue, he said, for "unlike the communicable killer diseases we have encountered most often in the past, HIV/AIDS is transmitted through the most intimate and private human relationships, through sexual violence and commercial sex; it proliferates because of women's poverty and inequality."[30]

SOCIAL AND RISK FACTORS Gender inequality deprives women of the ability to refuse risky practices, leads to coerced sex and sexual violence, keeps women uninformed about prevention, puts them last in line for care and life-saving treatment, and imposes an overwhelming burden on them to care for the sick and dying.

"Women are truly the most vulnerable in this pandemic.... Until there is a much greater degree of gender equality, women will always constitute the greater number of new infections," Stephen Lewis, UN Secretary-General Kofi Annan's Special Envoy for HIV/AIDS, in Africa told a reporter at the end of 2001.[31]

Socially defined gender roles determine differences between women and men in access to productive resources and decision-making. There are variations among societies, but whatever the superstructure, according to Lewis, the foundations always incorporate an unequal power balance in gender relations that favours men. Thus, he says, it is still a worldwide reality

15 **TARGETING CREDIT TO WOMEN IN BANGLADESH** A number of NGOs in Bangladesh direct credit to women. The Grameen Bank and Bangladesh Rural Advancement Committee (BRAC) have improved women's mobility, economic security, control over income and assets, political and legal awareness, and participation in public protests and political campaigning.

The programmes increase demand for contraception and help women overcome obstacles to their use. Both Grameen Bank and BRAC have family planning awareness programmes, and having a small family is one of the Grameen Bank's Sixteen Decisions that every woman has to memorize. Neither has offered family planning services (though BRAC has recently started providing contraceptives to some members) but this seems to be less important than the effect of economic empowerment on women: where services are available from other providers, empowerment is linked with contraceptive use.

Women feel empowered by credit despite the extra work it entails: they feel more self-fulfilled and valued by other household members and the community. The effect on fertility seems to be in addition to the impact of family planning programmes and other health care interventions.

Microcredit programmes have a more powerful impact if women are the borrowers: female borrowing has a significant effect on seven out of eight indicators boy's and girl's schooling; women's and men's labour supply; total household expenditure; contraceptive use; fertility; and value of women's assets other than land. By contrast, male borrowing was significant in only three out of eight. Household consumption increases by 18 taka for every 100 lent to a woman and by 11 for every 100 lent to a man.

that millions of women are effectively sexually subjugated and forced into risky sex, without condoms, "without the capacity to say no, without the right to negotiate sexual relationships."

Biology also works against women: women's physiology is more vulnerable to HIV and other sexually transmitted infections. Reproductive tract infections, which predispose to HIV infection, are more easily transmitted and less easy to diagnose in women. Vaginal scrapes and cuts suffered during violent or coerced sex increase the risks.

IGNORANCE ABOUT SEX IS EXPECTED In many societies, culture dictates that "good" women are ignorant about sex and passive in sexual interactions. This makes it difficult for women to inform themselves about risk reduction, and even more difficult, even if they are informed, for them to negotiate safer sex or the use of condoms.[32] A study in Zambia revealed that only 11 per cent of the women interviewed believed that a married woman could ask her husband to use a condom, even if she knew that he had been visiting prostitutes and was possibly infected.

Young women are particularly vulnerable and under-informed. In 17 African countries, surveys indicated that over half of the girls did not know any way of protecting themselves from HIV.[33] Yet there is much evidence that teenage girls are sexually active before marriage, indicated by the numbers of teenagers who drop out of school because they are pregnant. The "sugar daddy" syndrome, though more talked about than proved to be widespread, works against young women. HIV infection rates among young African women aged 15-19 in some urban areas are said to be five to six times higher than for young men.[34]

The strong norms of virginity and fidelity applied to women (but not to men), as well as the "shame" that prevents open discussion of sexual matters, make it very difficult for women to seek protection or treatment or even information about sexually transmitted diseases, and especially HIV/AIDS.

STIGMA A husband's family and the community at large may blame his widow for his death, and may refuse the usual support to her and her children. The law may allow the woman to inherit her husband's land and property, but local and customary rules often override it in practice. Stigma coupled with fear has even spawned lynch mobs when women are discovered to have the disease, or, as in the case of young South African activist Gugu Dhlamini, courageously reveal their HIV status.[35] The outcome has been tragic for many innocent women and their children.

ECONOMIC DEPENDENCY Women's economic dependency increases their vulnerability to HIV. Although women are the primary producers of food across much of Africa, they may not have any rights in the land they work or to the products of their labour. Inheritance may depend on local practice and in effect put them at the mercy of their husband's relatives.

This poverty and economic dependency make it impossible for many women either to negotiate the terms of their relationships or remove themselves if the relationship puts them at risk. It may force them to endure routine domestic violence, which both increases their chance of contracting HIV/AIDS and deters them from seeking testing and treatment. With few opportunities to earn livelihoods independent of men, many women are compelled to use sex to gain resources, increasing the risks to themselves and the men who use them.

DOUBLE STANDARD The power imbalance limits women's freedom in other ways. A 1999 Tanzanian study showed that while men sought voluntary counselling and testing without consulting their wives, women felt compelled to consult their husbands.[36] Initial Africa-based surveys are revealing that when anti-retroviral therapies become available, health facilities discriminate in favour of men.

Women are expected to be virtuous and faithful, to take care of their sick partners and children, support their families and comfort the dying. Yet they are denied support themselves or the information or treatment that could save their lives: and when their partner dies, they are held responsible.

Women's tragedy passes down the generations. Mothers often discover that they are HIV-positive only when they visit prenatal clinics. The risk of mother-to-child transmission is high, but

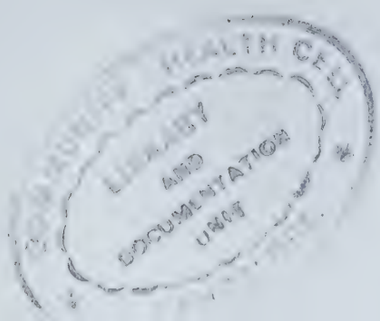
women have little support in reducing the risks—anti-retroviral therapy, advice on the alternative dangers of breastfeeding and of breast-milk substitutes, or continuing care or counselling.

Where treatment has been offered, it most frequently is for a brief period, to prevent infant infection, leaving the mother to face the prospect of her own death and worry about the fate of her orphaned children. Young children whose mothers die from any cause are at much higher risk of death themselves; their risks after an AIDS-related death may be higher because of the stigma and the possibility that they may themselves be infected.

Conflict situations, in which rape is used as a weapon of war spread the pandemic, as the virus is spread through sexual violence. In Rwanda today, many women who were raped in the genocide are now dying of AIDS, so for them the genocide continues.

TAKING ACTION, EMPOWERING WOMEN Empowering women is key to challenging the pandemic, preventing its further spread and rolling back the incidence of new infections. It is more urgent than ever to protect and improve women's health, including their reproductive health, and provide the information and services to do so; to decrease the gender gap in education and make education universal; to improve women's access to economic resources, increase their political participation, protect them from violence and enable them to achieve their rights to sexual and reproductive health and self-determination. The goals include real and equal partnership with men. They are ambitious but realistic, and more than ever necessary.

The global community has developed a serious set of blueprints for addressing inequality. Their recommendations are laid out in the Convention on the Elimination of All Forms of Discrimination against Women, the ICPD Programme of Action and the Platform for Action of the Fourth World Conference on Women with their five-year reviews. Many of the recommendations are included in the MDGs. Will countries accelerate their implementation of these recommendations, and will the international community provide additional resources to do so?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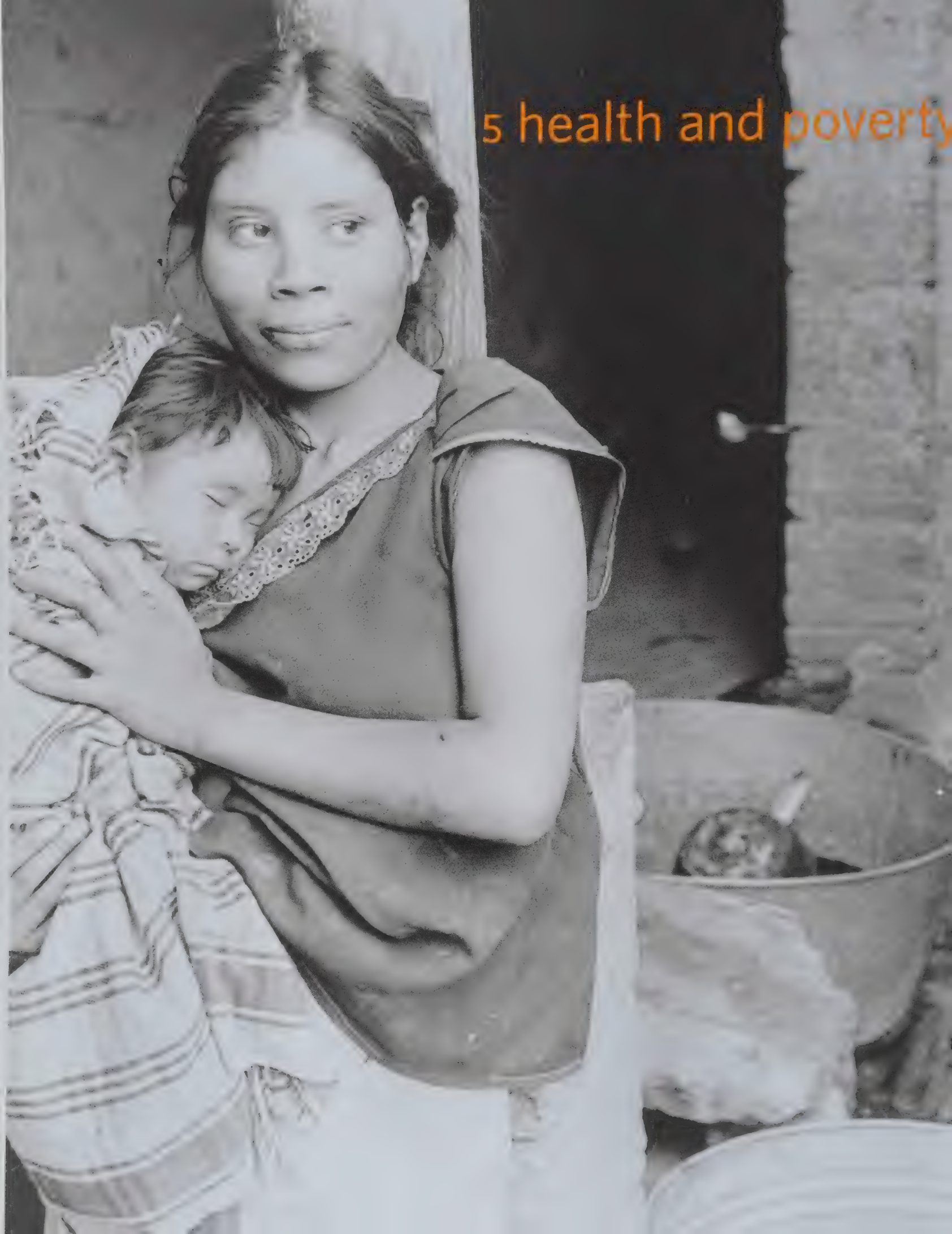


5 health and poverty

"The biggest enemy of health in the developing world is poverty."
–UN Secretary-General Kofi Annan, address to the 2001 World Health Assembly

Poor people are more often sick than the better off. Their general levels of health and well-being are lower. They are more exposed to communicable disease[1] and have less resistance to it. They are more likely to live and work in hazardous environments. They have less food and less access to clean water.[2] Their housing offers less protection from the weather and is more likely to be overcrowded.

They have less access to health care, and the services they do have are low in quality and do not respond to their needs. They get less respect and time from doctors and nurses. They are less likely to recover completely from illness, and die earlier. In addition, they are likely to fall even deeper into poverty as a result of working time lost to ill health and the cost of health care.

Poor people in a 41-country survey cited illness most frequently as the cause of destitution and the reason for a slide into poverty.[3] The threat of loss of work time and income is a constant fear. Many of the near-poor are just a serious illness away from poverty, and the poor that close to destitution. Poor people see ill health, disease and poverty as fundamentally linked.[4]

Poorer and less-educated people are more likely to have physically demanding jobs, yet they are less physically fit,[5] and malnutrition undermines their strength.

Reproductive health is a vital component of overall health.[6] More than one fifth of the burden of disease among women of reproductive age is connected with sex and reproduction. In sub-Saharan Africa, the figure is 40 per cent.[7]

AIDS is a disease of poverty, and has thrown many families into poverty. In the 1990s, AIDS reduced Africa's per capita annual growth by an estimated 0.8 per cent. Statistical models show a grim future. Two decades from now in the worst-affected countries, economies may be 20 to 40 per cent smaller than they would have been without AIDS.[8]

16 **POVERTY KILLS** Globally, there is a stark relationship between poverty and poor health: in the least-developed countries, life expectancy is just 49 years, and one in ten children do not reach their first birthday. In high-income countries, by contrast, the average life span is 77 years, and the infant mortality rate is six per 1,000 live births.

BEYOND INCOME: HEALTH AND WELL-BEING The linkage between health and poverty is fundamental. "Poor people define poverty in the conventional way—lack of income—but also as instability, worry, shame, sickness, humiliation and powerlessness."[9]

The poor recognize multiple dimensions of health: "Good health is identified as a central component of a good quality of life. In their descriptions of well-being, three different types can be identified: *material well-being*, often expressed as having 'enough'; *bodily well-being*, to be strong, healthy and good-looking; and *social well-being*, which includes having children and caring for them, self-respect, security and confidence in the future, freedom of choice and action, and being able to help others."[10]

Early childbearing in marriage helps define social well-being, and is a nearly universal expectation among poor people in developing countries (over 90 per cent of first births occur within a year of marriage). It is only later in life, and not yet in all societies, that spacing and limiting the number of children overall is recognized and welcomed as part of social well-being.

It will be some time before this changes. Poor young people, married or not, have less access to family planning than their older siblings or the better off. Delaying marriage and the first birth comes with better education and social acceptance of wider choices for young women.

The poor often take their partners early in life. Poor young women are more likely than the better off to be enticed or forced

Figure 3: Determinants of health-sector outcomes
Biological, cultural, environmental, social and institutional conditions influence health risk and susceptibility among different populations. Describing the differences in health outcomes among wealthier and poorer subgroups helps to indicate where special efforts are needed.

Source: World Bank

into their first sexual experience. They (and their families and communities) are more likely to see having children as a source of esteem. To poor people, whose needs are immediate, high barriers to education may make its possible future rewards appear remote.

In communities where family planning has not been fully accepted, people see births and family size as unchangeable conditions, within which they make other choices. It is only when people recognize that they can control the number and spacing of their children that they begin to see larger families as a drain on well-being and report larger numbers of children as a cause of poverty.[9]

Reproductive Health and Poverty

Reproductive health issues are fundamentally different from almost all other health concerns. Sex and reproduction are at the core of life, a source of joy, affection and spiritual connectedness. Out of this feeling women especially expose themselves to the risks of sex and reproduction.

RIGHTS DENIED Worry about their reproductive health is also, particularly for women, another of the insecurities that mark the experience of poverty. In the absence of family planning—to which poor women have less access than the better off—the risk of unwanted pregnancy can make any sexual encounter a source of worry;[11] the possibility of a sexually transmitted infection, particularly HIV, adds to the insecurity. Pregnancy can be a hazardous and worrisome time; childbirth can lead to illness, debilitating injury or death.

Lower fertility, including fewer unwanted births, leads to better health outcomes for women and children. Unwanted children are more prone to respiratory and diarrhoeal infections than wanted children. Wanted or not, each additional sibling reduces the chance of a child receiving treatment by 2 to 8 per cent. Where vaccination levels are low, wanted children receive 50 to 100 per cent more vaccinations than unwanted ones do.[12]

SOCIAL CONSTRAINTS People in many cultures find it hard to discuss sex and reproduction. In these circumstances exercising choices—planning for contraceptive use, for example—can be experienced as shameful and humiliating. Discussing gender-based violence, particularly sexual violence, is especially hard for poor women.[13]

There is another crucial difference regarding reproductive health. Only women bear children. They are exposed to risks that men cannot fully appreciate. Women are also more exposed to shared risks, such as sexually transmitted diseases, for reasons both of biology and of social disadvantage.

Social constraints affect women's reproductive health care. Men are more likely to use formal health services, partly because they control the money needed to pay for them. Women are more likely to rely on traditional or other alternative services, because they are cheaper, closer at hand and more familiar.[14] A woman may be unwilling to travel alone, or not allowed to go to health services without the approval of her husband or another man in the family or community.

Women's experience of health care also affects the way they use it: they are not guaranteed sensitive treatment at the clinic or hospital. Health workers tend to look down on poor women. Illiterate women in particular may feel unable to describe their condition or understand the advice they are given.

The reproductive health needs of the poor, and poor women in particular, do not command the attention of policy makers, or even of women themselves. The poor give priority to their many immediate and pressing needs. Pregnancy and childbirth are taken for granted—and so are the attendant risks, though they come from easily preventable causes.

17 REPRODUCTIVE HEALTH FOR BANGLADESH'S URBAN POOR Bangladesh's urban population is growing by 6 per cent a year, three times the national growth rate. Growth is fastest in the slums, where there are some 225,000 persons per square kilometre. Half of slum inhabitants are poor; 30 per cent are classifiable as hard-core poor.

Rapid urbanization has produced degrading environmental and health conditions. Diarrhoea is almost twice as prevalent in the crowded slums of Dhaka and Chittagong as in rural areas. Malnutrition, tuberculosis, vaccine-preventable diseases and sexually transmitted infections are also more prevalent; immunization rates are lower.

Women in the slums have limited access to reproductive health information and care because health centres are not conveniently located. As a result:

- 93 per cent of married teenagers have begun childbearing;
- 22 per cent of girls give birth before age 15;
- 63 per cent of women have never used a modern method of family planning;
- 40 per cent became pregnant unwillingly due to lack of knowledge of services.

Under the Urban Primary Health Care Project, supported by UNFPA, the Asian Development Bank and the Norwegian Agency for Development Cooperation, 14 experienced NGOs are strengthening reproductive health services and training staff and managers.

Nine city-run maternity centres in Dhaka and 16 NGO-run clinics have been upgraded to comprehensive reproductive health centres. These handle referrals from 190 primary health care centres, and will eventually provide: pre- and post-natal care and normal delivery services; emergency obstetric care; clinical and non-clinical contraceptives; and treatment for reproductive tract and sexually transmitted infections.

So far, about 200 doctors, paramedics, counsellors and laboratory technicians have been trained in care and counselling. Ten centres now provide caesarean section delivery.

Within urban communities, the project provides information on safe motherhood, breastfeeding, family planning, sexually transmitted infections and HIV/AIDS.

Measuring Health Differentials between Rich and Poor

Health gaps between rich and poor are generally wider in poorer countries than richer ones, but this does not have to be so. Countries that design their health systems to promote equality can show a narrow range of difference, regardless of income. Viet Nam has reduced the differences between richest and poorest on most health measures (including those related to reproductive health) to less than two to one.[15]

This applies to rich countries as well as poor ones. In the United States, the country that spends the most on health care per capita in the world, inequalities in access to health care are higher than in other industrialized states. These disparities mean that overall health performance is worse; for example, infant and child mortality in the United States is higher than in most European Union countries.

INFANT MORTALITY AND WEALTH A study of infant mortality and reproductive health indicators in 44 developing countries[16] reveals very wide differences between regions, and between rich and poor within countries. National averages tell only part of the story: child survival and reproductive health are matters of internal equity as well as overall wealth or poverty.

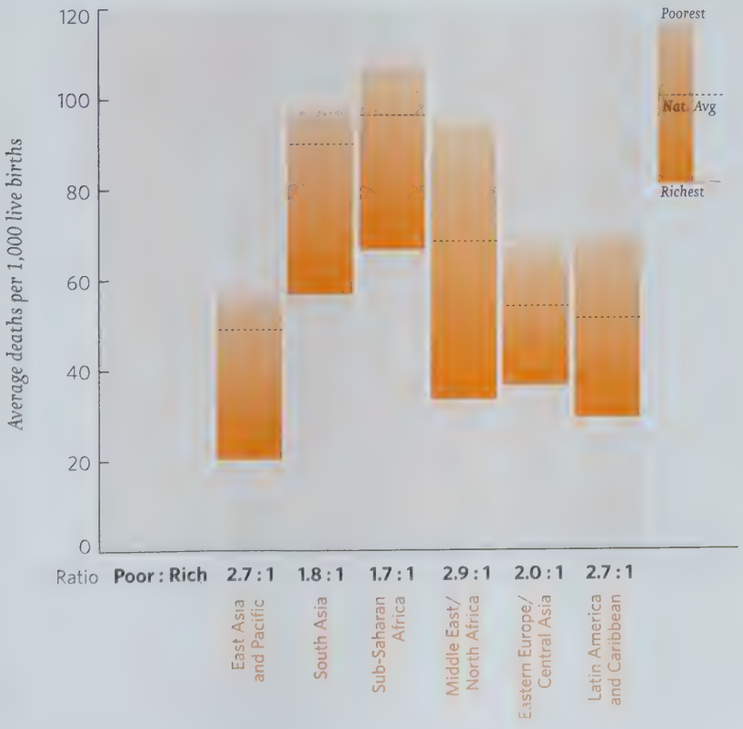
Child survival and child health are tied to income levels, between and within nations. Child mortality levels in some poor communities in the United States, for example, rival those in Panama.[17]

Poor infants and children are more likely to die than children in better-off families. In some countries, for example, the under-5 mortality rate of the poorest 20 per cent of the population is more than four times that of the richest 20 per cent.[18] Comparing 44 developing countries, the average infant mortality rate in the poorest families is twice as high as in the richest families. The goal of halving infant mortality could be reached in several regions by bringing national averages down to the levels of the richest 20 per cent.

But in some regions it will be more difficult. In sub-Saharan Africa and South Asia, which have the highest infant mortality, the gap between the richest and the poorest is smaller, and even among the richest 20 per cent infant deaths are higher than the average in other regions.

Health risks to infants and children are worse in poor families with many children. Larger families are more common among the poor and the children in them are less likely to receive even basic preventive health care.[19] If the children become ill, they are less likely to be treated. If the sick child is a girl, her risks can be even higher.

Figure 4: Infant mortality differentials
Average deaths per 1,000 live births, richest fifth to poorest fifth of population, by region



SAFE MOTHERHOOD In any country, poor women are far more likely than rich women to die in childbirth. Rates of maternal mortality show a greater disparity between rich and poor nations than any of the other commonly used public health indicators, including infant mortality rates. Maternal mortality is a function of access to resources and access to care: women who become pregnant in developing countries face a risk of maternal death 80 to 600 times higher than women in developed counties.[20]

A woman's lifetime risk of dying due to maternal causes (pregnancy, delivery and related complication) is:

- in Africa, one in 19;
- in Asia, one in 132;
- in Latin America, one in 188;
- in more-developed countries, only one in 2,976.[21]

A mother's death is more than a personal tragedy. It can have severe consequences, not only for her family, but also for the community and the economy. When mothers die, their young children are also more likely to die.[22]

Approximately 500,000 women die each year from maternal causes, and many times that number suffer illnesses and injuries associated with pregnancy and childbirth.

Ninety-nine per cent of these deaths occur in developing countries.[23] These maternal mortality differences reflect both higher risk and the larger number of births in developing countries.

Unwanted fertility, leading to the birth of unplanned and unwanted children, is higher in poorer settings and among the poorest of the poor. There is less information on maternal morbidity[24] but the differentials are likely to be similar, since the causes—lack of information, access, community and family support, finance, transport and provider quality[25]—are broadly the same as those that produce unwanted children.

There are also wide differences within countries. The outcomes of pregnancy depend on the health and age of the mother, her

nutritional status, her prior pregnancy history and the spacing between her previous births, as well as her available resources, her education and her access to information and services.

Protecting the health of mother and baby requires:

- good antenatal care;
- skilled attendants;
- a safe place to give birth;
- access to emergency obstetric care.

Most maternal deaths could be prevented. Complications of pregnancy and childbirth are a leading cause of death and disability for women aged 15-49 in most developing countries. Better care in childbirth and more access to it would substantially reduce maternal mortality.

Poorer women do not have access to the more costly services before or during delivery. Access to and use of maternal services still tend to be more affected by wealth than either contraceptive use or completed fertility (see figures below), perhaps because of the relatively high fees for attendants or hospitals.

GOOD ANTENATAL CARE The lower a woman's income, the less likely she is to seek antenatal care, but restrictions on women also reduce access. In 44 countries studied, more than three quarters of pregnant women visit a doctor, nurse or midwife at some point in their pregnancy. In South Asia and North Africa, where women's mobility is more restricted, the figure is nearer one third.

The gap between rich and poor families is greatest when national averages are lowest. In South Asia the gap between the richest and poorest groups results from particularly high levels of care among the richest—even in relation to the next 20 per cent. In North Africa, where the rich/poor gap is even greater, differences between the wealth groups are more evenly distributed.

SKILLED BIRTH ATTENDANTS Poorer women are even less likely to have skilled assistance at delivery than to seek antenatal care. In Asian countries and sub-Saharan Africa they are half as likely. In North Africa, however, women are more likely to give birth with skilled assistance than to seek care during pregnancy.

Increases in antenatal care and attended delivery as wealth increases are sharper than for other basic health care services, such as oral rehydration therapy or medical treatment for diarrhoea, medical treatment for acute respiratory infections or immunization. Attendance by a doctor is the most sensitive to income.[26]

A SAFE PLACE TO GIVE BIRTH Childbirth at home or in a health facility is also strongly related to wealth. In the 44 countries studied, nearly 80 per cent of the poorest quintile have their children at home. Nearly 80 per cent of births in the richest families are at a health facility, as are most births in the two richest quintiles. At each lower wealth group, the proportion of home births increases.

FERTILITY AND CONTRACEPTIVE USE There is little difference in fertility between income groups in countries with fertility rates above six children per woman (for example, Nigeria, Mali, Madagascar, Malawi, Niger, Zambia, Burkina Faso, Benin and Uganda). The wealthiest tend to have fewer children than the poorer, but total fertility is never as low as four.

In Latin American countries, where fertility ranges from about 3.5 to 5.1 children per woman, the differences by wealth group are among the largest in the world. In six countries, the wealthiest quintile has fertility rates below replacement (less than 2.1 children), while the poorest have 2.5 to 3.5 more children per woman.

In intermediate-level fertility countries in Europe and Asia, the wealthiest families are at or below replacement level fertility and the poorest have more than twice as many children (4.6 in

Figure 5: Antenatal care differentials
Per cent of pregnant women served by a doctor, nurse or midwife, poorest fifth to richest fifth of population, by region

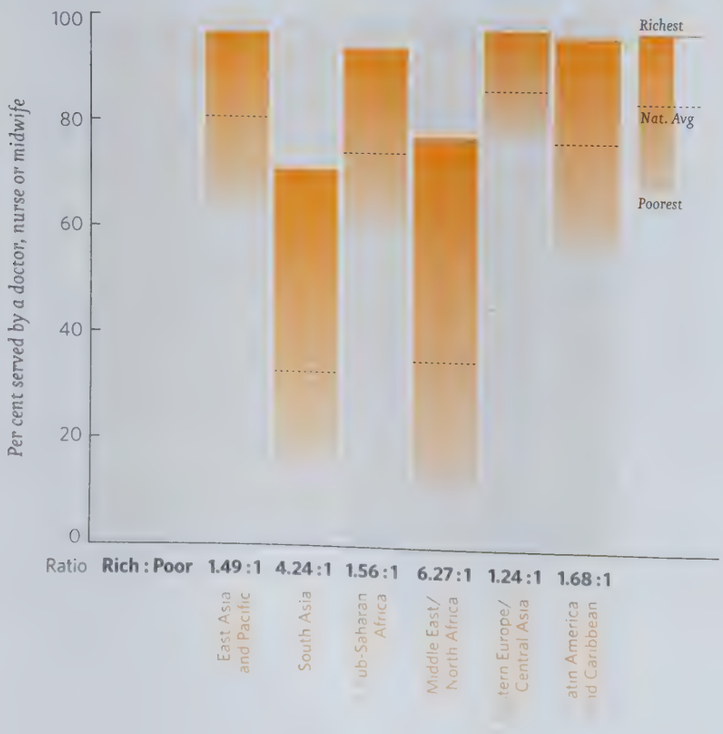
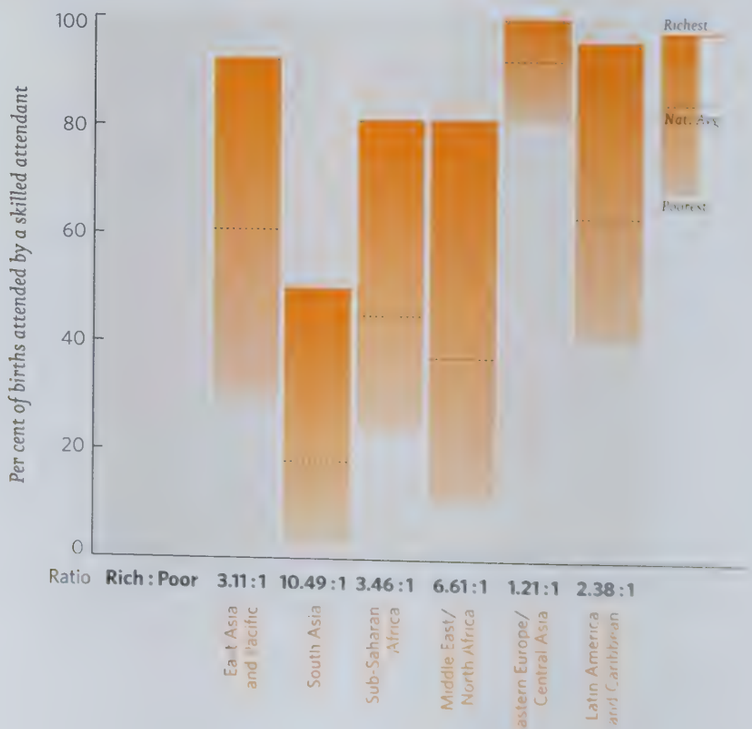


Figure 6: Trained delivery differentials
Per cent of births attended by a skilled attendant, poorest fifth to richest fifth of population, by region



Kyrgyz Republic). In the Asian countries reviewed (national fertility between 2.3 and 4.9) not all the wealthy groups have reached low fertility levels. In five, the wealthiest have reached fertility levels at or below replacement while the poorest are higher (between 3.1 in Viet Nam, and 6.5 in the Philippines). Other countries are earlier in the transition. In Nepal only the wealthiest had fewer than four children (2.9). In Pakistan only the wealthiest had as few as four children, and all groups of poorer women had between 4.9 and 5.1.

FAMILY PLANNING USE Differences in access, acceptance and use of family planning accounts for most of the difference in the fertility of rich and poor.

The higher the overall level of women's contraceptive use, the lower the differential between women in the richest and poorest groups. Once family planning use exceeds 40-45 per cent overall, the differences between wealth groups narrows considerably, and family planning becomes accepted as the norm.

In sub-Saharan African countries, where contraceptive prevalence is only around 10 per cent, the richest use family planning more than five times as often as the poorest.[27] In Pakistan, the country with the lowest overall prevalence in South Asia (9 per cent) the difference is 20 times. In Nepal, with a prevalence of 26 per cent, the difference is less than three times. Differences are large in the Philippines, where contraceptive use is low; but in Indonesia and Viet Nam, where contraceptive prevalence is high, wealth differentials are relatively low. Several European and Central Asian countries have reached overall prevalence levels of family planning close to 50 per cent, with lower differences between richer and poorer.

In Latin America, overall contraceptive prevalence rates are high. In the lower-prevalence countries, internal wealth differentials are greater. In high-prevalence countries, family planning is widely accepted, and other factors contribute to a varied relationship between wealth levels and prevalence. In North Africa, the rich are twice as likely as the poor to use contraception.

ADOLESCENT CHILDBEARING The poorest women start their childbearing earliest. In many developing countries, poor women start bearing children between ages 15 and 19. Their higher levels of pregnancy reflect early marriage, less ability to negotiate delays in sex and reproduction, and less access to family planning.

Countries with low adolescent fertility overall have larger differences in fertility between poorer and richer young people. The exception is Latin America, with a relatively high overall level of adolescent fertility and wide differences between the wealthiest and poorest. The poorest families have extremely high rates of childbearing among the young.

In Indonesia, the Philippines and Viet Nam, the poorest adolescents are nearly seven times as likely to have children as their better-off counterparts. In the Philippines, poor young women are nearly 11 times as likely to have a child. In all three countries, reductions in youthful fertility are systematically related to increases in wealth.

In Egypt, adolescent fertility differences reflect wealth levels in a regular way. In Morocco, adolescent fertility is much lower in wealthier than in poorer families.

Countries in Europe and Central Asia do not show a regular relation between wealth and adolescent fertility, indicating a complex interaction among service access, ethnic variation and regional differentials. The wealthiest subgroups still have the lowest adolescent fertility, however.

Latin American countries show a large gap between the poorest group (ranging from 105 to 234 births per thousand adolescent women) and the three middle quintiles, and another large

Figure 7: Fertility differentials
Births per woman, richest fifth to poorest fifth of population, by region

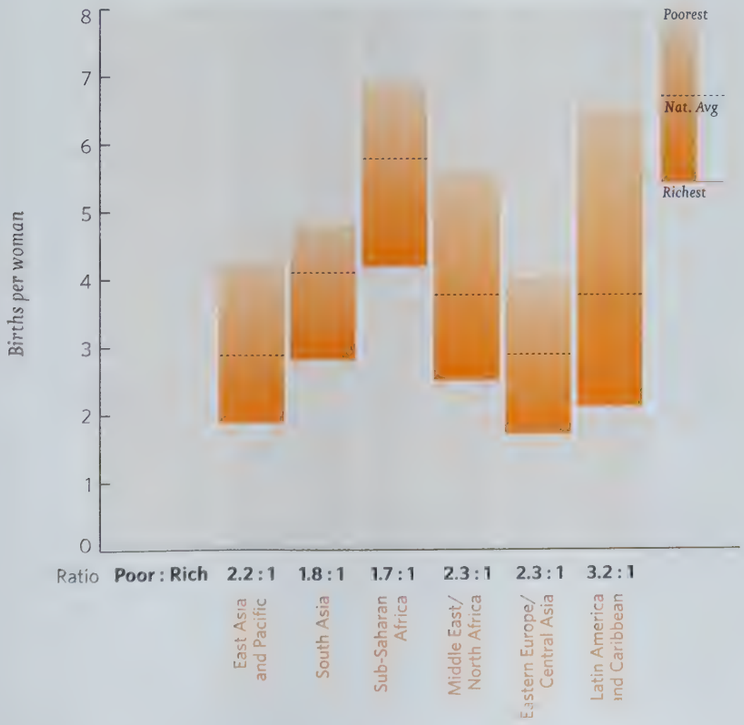
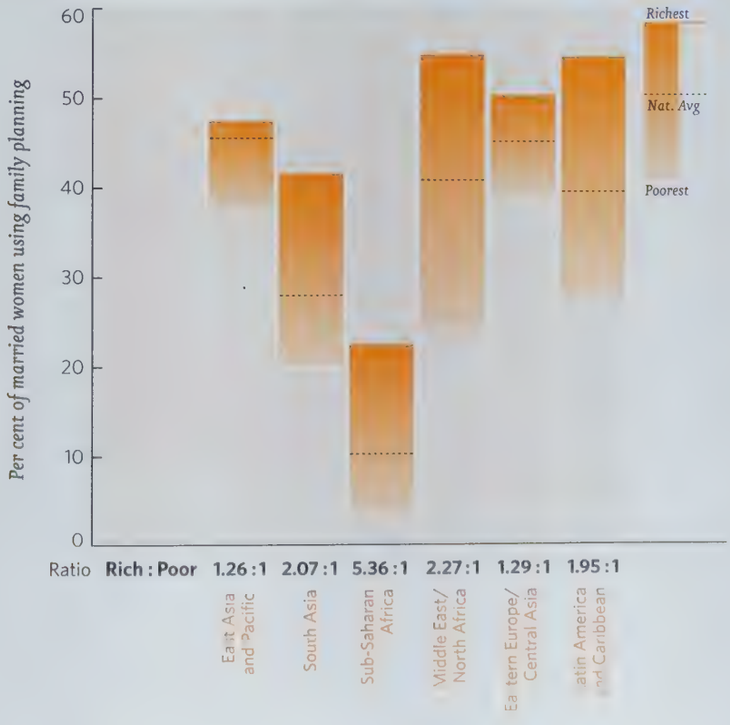


Figure 8: Family planning differentials
Contraceptive prevalence, poorest fifth to richest fifth of population, by region



gap between these intermediate groups and the wealthiest (ranging from 18 to 58). Only in Haiti, the poorest country in the region, does a single large gap occur between the richest quintile and the four poorest.

In some of the 22 countries reviewed in sub-Saharan Africa, adolescent fertility decreases with higher wealth.[28] Many others show a large difference between the wealthiest group and the others but there are no systematic differences among the poorer groups, probably because these are all least-developed countries, and the wealthier are well-to-do only in comparison with the poorest. Compared to other regions, nearly everyone is very poor.[29]

OVERVIEW OF DIFFERENCES BY WEALTH There are glaring differences in infant mortality between poorer families and the better off. The "reproductive health gap" between wealthier and poorer is often at least as wide. The largest overall difference between the poorest and wealthiest groups is in assisted delivery (an expensive service), but the measure that most clearly sets one income group off from the next is adolescent fertility. The teenage pregnancy gap between richer and poorer is wider than the gap in both trained birth attendance and infant mortality.

The use of family planning services depends less on cost than on personal motivation and institutional commitment to providing the service, so older age groups show smaller gaps between richer and poorer. For the young, early marriage, social pressure and reluctance to spend public money on protecting their reproductive health increase the dangers of being both young and poor.

NON-WEALTH-BASED HEALTH DIFFERENTIALS Well-being and wealth depend on more than income and bank balances. Physical and social infrastructure, opportunities, resources, skills and information all add or subtract, reinforced by complex social processes of inclusion and exclusion. Geographical location is important: rural areas provide lower levels of services, information and opportunities than urban areas.

Some of the reproductive health differentials reflect rural poverty, but differences can be seen within both urban and rural areas.[30] Fewer rural residents reach the income levels seen in cities, but the poorest have the worst services in both. In India, for example, total and adolescent fertility levels, contraceptive usage and immunization levels are very similar across the wealth spectrum in rural and urban areas. The poorest in rural areas are more disadvantaged than their counterparts in cities—rural families have less access to safe delivery services, particularly if they involve highly trained personnel or specialized facilities. In the richest groups, the differences are minor.[31]

Urban areas are growing rapidly, and the majority of the world's poor will soon be urban.[32] In theory, economies of scale and ease of access could increase coverage, but there are already large inequities in access to basic services within cities. On the other hand, smaller cities, while better served than rural areas, compare poorly to larger cities.[33]

The relative disadvantage of medium-sized cities in providing health quality and service is a growing problem as a larger proportion of urban dwellers comes to live in them.[34] Municipal and other local authorities have more responsibility under the decentralization of public health administration, an aspect of health reform, without the corresponding resources or revenue-raising authority. Local governments will find it increasingly difficult to fill the gaps in services.

Figure 9: Adolescent fertility differentials
Births per thousand women aged 15-19, richest fifth to poorest fifth of population, by region

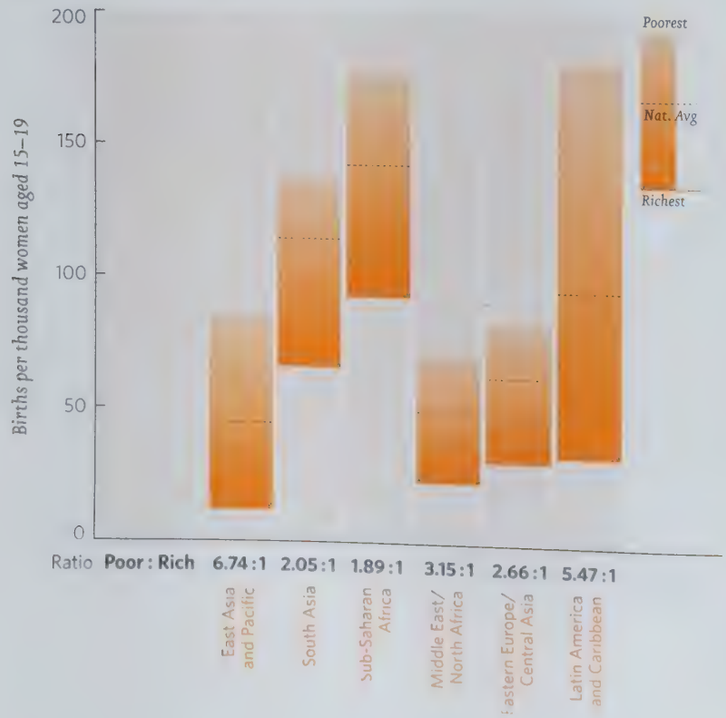
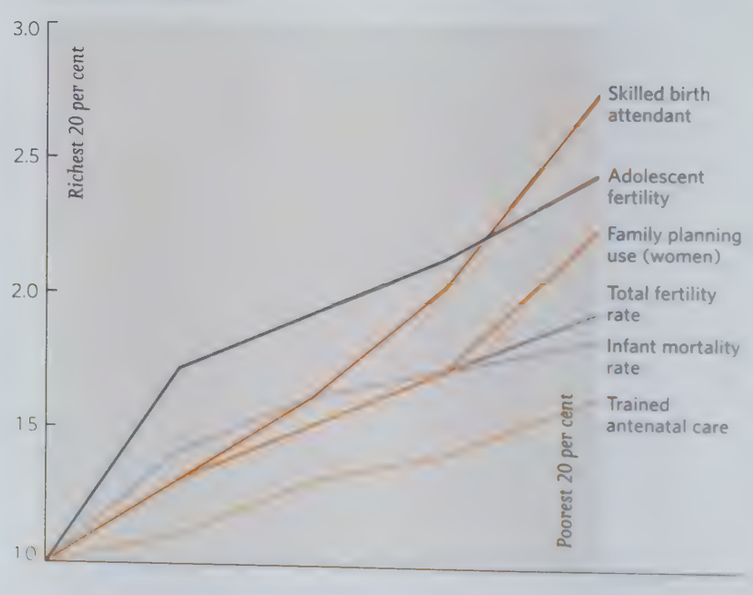


Figure 10: Relative disadvantage of successive wealth groups on elements of reproductive health



Supporting More Equitable Health Care

Investment in basic health services in developing countries is only a fraction of what is needed. Low-income countries are spending only $21 per capita per year for all forms of health care, much of it directed to expensive curative services to the detriment of basic health prevention and care. The WHO/World Bank Commission on Macro-economics and Health[35] estimated that an additional $30 billion per year is needed. The poorest countries either have more urgent priorities, such as debt servicing and repayment, defense or industrial development, or lack the financing altogether.

HEALTH SECTOR REFORM These constraints have forced the health sector to seek more effective use of available resources; to improve the accountability of providers and regulators; to create additional revenue from fees for service and other charges, and to find ways to guarantee resource flows. These initiatives are referred to as "health sector reform".

18 **HEALTH SECTOR REFORM IN BRAZIL** Brazil's unified health system, established in 1988, has a basic care package that includes family planning, reproductive health and STI/HIV prevention and treatment.

Since the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women the unified health system has undergone reform, including additional financing for health care and rapid decentralization. As a result, reproductive health care is increasingly being integrated with municipalities' primary health services.

BEMFAM, the International Planned Parenthood Federation affiliate in Brazil, contracts with municipalities in 14 of Brazil's 27 states to assist with sexual and reproductive health programmes.

Adolescent reproductive health programmes, however, have not fared so well. According to a recent study of adolescent reproductive health in São Paulo, structural adjustment policies and health sector reform have left more young people uninsured, cut public spending on health, reduced numbers of health care personnel and created shortages of medical supplies. All these have held up implementation of high-quality health services for adolescents.

19 **THE PURPOSE OF HEALTH SECTOR REFORM** According to UNAIDS, "Prolonging life and reducing morbidity are not the only purpose of health care systems, and of health care reform. Producing health care procedures, 'interventions', is not its only output. Health care reform has to aim at more than good health status. As soon as one accepts that people, not health care systems, produce health, then one realizes that relief from suffering, irrespective of health outcomes, and autonomy, the capacity of people to maintain their health on their own, become equally important purposes of the health care system."

Putting the health sector on a solid financial footing can also improve the efficiency and quality of overall health services and promote equity in health care. In their five-year review of the ICPD Programme of Action, governments recognized that countries must include reproductive health in health sector reform.

> *"Governments, in collaboration with civil society, including non-governmental organizations, donors and the United Nations system, should: (a) Give high priority to reproductive and sexual health in the broader context of health sector reform, including strengthening basic health systems, from which people living in poverty in particular can benefit...."*[36]

MAKING REPRODUCTIVE HEALTH A PRIORITY There is no guarantee that countries will make reproductive health a priority under reform, particularly in decentralized systems. However, essential health service packages usually include some reproductive health components, including safe motherhood, family planning and action against sexually transmitted infections including HIV/AIDS.[37]

According to WHO, Colombia's health sector reform, which includes reproductive health, "has led to more financial resources for health care, an emphasis on more efficient use of resources, decreased donor dependence, broad-based support for health promotion and preventive care, and special attention to underserved groups. All of these sector-wide trends have had positive impacts on the delivery of reproductive health services in Colombia."[38]

Zambia began one of Africa's most ambitious health sector reforms in the early 1990s. The reformed and decentralized health system includes an essential health package with components of reproductive health (maternal and child health, family planning, and prevention and treatment of STIs and HIV/AIDS), action against malaria and tuberculosis, and attention to water and sanitation. Adolescent reproductive health, action against gender violence, and prevention of abortion are embedded in the package.[39] These reforms have not been fully implemented, in part because of the lack of resources to support the package of services and drugs.

Special care is needed under health sector reform to protect supply chains. In Ghana, health reform has neither harmed nor helped contraceptive supply, in part because the contraceptive logistics system is a separate element, and donors supply the commodities.[40] In Kenya, the good performance of a similar contraceptive logistics system gave the ministry of health some ideas for reforming its logistics system for essential drugs.[41]

PARTNERSHIPS Public-private partnerships can improve access to services. Bolivia established a separate organization, PROSALUD, as part of health sector reform in the mid-1980s. Designed to improve equitable access to better-quality and cost-efficient basic services, including reproductive health, PROSALUD operates more efficiently than the ministry of health, and has become a leader in health care delivery.[42]

In Bolivia and other Latin American countries NGOs are strong advocates for reproductive health and clients' rights to quality services within health sector reform. "The involvement and empowerment of clients, through civil, societal and actual con-

sumer inputs in health service design, delivery and evaluation, is helping to make clients more aware and more demanding of the services they receive."[43]

HIV/AIDS has a profound impact on health sector reform and civil society mobilization, particularly in Africa where governments were often slow to react. Experience in Phayao Province, Thailand, which has had the highest rate of reported AIDS cases in the country, has shown that an effective response to AIDS demands more than a health care package. It calls for reorganizing the health system to provide care, catalysing community action to promote behaviour change, and integrating health concerns into the core business of all sectors of society.[44]

EXPENDITURES, ACCESS AND QUALITY Government health spending tends to favour the rich, mostly because a disproportionate share goes to curative care and hospitals, which are more frequently used by the rich, rather than to services the poor rely on, such as clinics.[45] A comparison of the public spending on health devoted to different income quintiles in 12 countries from different regions[46] illustrates this inequity. In a majority of the countries, the richest 40 per cent receive a larger share of the total outlays than the poorest 40 per cent. In only four countries, all of them in South America, do the poorest and richest 40 per cent receive a comparable share of public resources.

In six African countries, "the highest 20 per cent of the population gets about one-and-one-half times as large a benefit from government primary health care programmes as the lowest 20 per cent."[47] A study in India showed that around 32 per cent of the benefit from public health services goes to the richest population quintile, compared with around 10 per cent to the poorest quintile.[48] The poor-rich inequalities are considerably larger in India's poorest states and in rural as opposed to urban areas. They are less marked in outpatient and primary health care services than in hospital-based services, but most government expenditures go to hospital care. The exception is immunizations, which tend to be more equally distributed across socio-economic groups.

Some countries show fewer disparities. In Viet Nam, for example, the poorest receive nearly their proportional share of reproductive health expenditures. Where the richer capture more than their proportional share it is because they go to hospitals or high-level clinics for services such as contraception, which the poor obtain from more modest facilities.

Smaller gaps in service distribution between rich and poor do not translate into equitable access to information and services. The poor are still exposed to higher levels of risk more frequently than the rich. If need rather than population size is the measure for health expenditures, the poor fall far short of their fair share.

MEASURING THE QUALITY OF HEALTH SYSTEMS Equity in the health sector is often defined as equal access to health services according to need, financed according to ability to pay. This is or should be one aim of reform in the health sector. However, there is little practical evidence to guide how to achieve equity at the same time as making public and private health care more efficient, cost-effective, and sustainable.[49] One way to promote equity is to emphasize services the poor can use, including family planning, safe motherhood and other elements of reproductive health. Care should be taken to protect these services under decentralization.

Paradoxically, the poor often do not use government health services, even when they are available.[50] One reason is that the poor, like all other groups, respond to quality when making choices for health care, and the poor usually receive the worst quality care—harsh treatment by poorly motivated, low-paid staff who demand payment for care and often have little to offer. The health workers are themselves often victims of poorly functioning health care systems that fail to provide the drugs, equipment and support the staff need to do their jobs.[51] So, in many countries, poor people would rather pay private-sector or NGO providers for what they see as better quality.[52]

The 2000 *World Health Report* concluded that health and well-being depend on how well health systems perform. Virtually all

20 **AIDING THE POOREST IN PALESTINIAN TERRITORY** Poverty is a major challenge in the Occupied Palestinian Territory, with more than a third of the work force unemployed and nearly half the population living on less than $2 a day. Poverty rates are highest among the rural population and female-headed households.

Maternal mortality, estimated at 70-80 per 100,000 live births, reflects both gender inequality and the poor state of health services. Early marriage (median age 18 years) also contributes to rapid population growth, making poverty alleviation more difficult. Women lag far behind men in educational achievement and labour force participation.

UNFPA is working to improve the quality of life of the Palestinian people by improving their reproductive health, through interventions focused on women and youth. Thirty-nine UNFPA-supported clinics in the West Bank and Gaza provide family planning, gynaecological care and counselling, at locations selected to serve those who would otherwise lack access to care.

Three model centres serve the most underprivileged areas, including two refugee camps, El-Bureij and Jabalyia. Here, social, psychological and legal counselling services are linked to reproductive health service provision. The poorest clients are exempt from payment for service, and are also referred to charitable agencies that offer subsidies for food and basic services.

The Fund also works with Palestinian parliamentarians and ministry officials to increase understanding of population-development links and adopt policies that more effectively address development concerns. It played a catalytic role in creating a committee of ministries and civil society groups for intersectoral planning and coordinated implementation of programmes that support the poor.

health systems could make better use of resources: misuse "leads to large numbers of preventable deaths and disabilities, unnecessary suffering, injustice, inequality and denial of an individual's basic rights to health."[53] Proposals to strengthen the delivery of health services include suggestions that governments should change their role from provider to financer, providing subsidies and letting the poor choose among providers in the private and NGO sectors.

Financing mechanisms[54] in large part determine where health care is available and who has access to services, which affects not only equity and quality[55] but also the degree to which people are protected from catastrophic costs due to illness.

USER FEES Most governments recognize that they cannot provide free services for all citizens with funding from general revenues and taxes. However, few people in developing countries have access to social or private insurance, and fees for service are becoming more common.

Fees were introduced in public health services to relieve financial pressure and help pay for improved quality,[56] but reports about their effect on the poor are mixed and contradictory. Some studies show that small increases in user fees have no adverse affect, particularly if the quality of care improves,[57] but there is ample evidence that user fees have denied poor women and children needed health care.[58] Removing fees can also create problems: in one health district in South Africa, removing user fees for all primary care in 1997 brought more patients to curative services, but that led to clinic congestion and reduced consultation times and may have discouraged mothers from bringing their children for antenatal care, growth monitoring and immunization.[59]

Most countries with user fees also have exemption schemes for the poor, but exemptions have been difficult to implement and enforce. In Uganda, for example, guidelines allow for an exemption rate of around 30 per cent for the poor. However, those who cannot pay are more likely to be turned away than to be exempted from paying; many poor patients believe it is pointless even trying to get health care under these conditions.[60] Reports from Lesotho, Ghana and Bangladesh also suggest that those who need the exemptions do not get them.[61]

OTHER APPROACHES Community-financed schemes show promise, but most communities need government support to set them up, as in Indonesia's Dana Sehat system,[62] which covered 13 per cent of Indonesia's villages in 1994. India and China have also used community-financing schemes for health care.

Social financing or social insurance can increase access to reproductive health care. The West African Society for Prevention of Maternal Mortality set up a fund to buy fuel for emergency transport to obstetric facilities in Kebbi State in Nigeria.[63] In Indonesia, a successful community insurance scheme resulted in more women reaching emergency obstetric care.[64]

Managed care, introduced in Latin America as part of health reform, has exacerbated inequalities. Health maintenance organizations have skimmed off the young and relatively healthy who make few claims, leaving under-funded local governments to cover the older, sicker, and more expensive patients.[65]

Services need to balance the need for revenue with the needs of service users, especially the poor. The poorest of the poor—the estimated 1.2 billion people who live on less than $1 a day—cannot afford to pay fees, however low, in whatever form, for health care. Formal and informal fees widely imposed around the world to shore up sagging health budgets are effectively denying access to even primary and reproductive health care to millions of the poorest people.

HEALTH AND ECONOMIC GROWTH Better health, including reproductive health, and education, contribute to economic growth.[66] Improvements in health and mortality help the poorest people most, because they are most at risk.[67] Better education helps women especially to protect their own and their children's health and widens economic choices. Higher incomes improve living environments, reduce malnutrition and provide a buffer against the costs of poor health.

As incomes rise people become healthier on average, but at the same time health inequalities increase, possibly because the better off are first to take advantage of the new health technologies that accompany economic growth. The result is that countries with higher overall per capita income have steeper child health inequalities than poorer countries where there are wide gaps between richest and poorest.[68]

6 HIV/AIDS and poverty

HIV/AIDS is the deadliest and fastest spreading of the diseases of sex and reproduction. It poses a greater threat to development prospects in poor countries than any other disease. The impact is hardest among the poor, who have no economic cushion and the weakest social support of any group.

Twenty years after the first clinical evidence of AIDS, it has become the most devastating disease yet faced by humanity, striking, on average, 14,000 men, women and children daily, the leading cause of death in sub-Saharan Africa and the world's fourth biggest killer.

The disease spreads through infected blood products and drug abuse, but overwhelmingly by sexual contact, predominantly between men and women. Women are more vulnerable to infection for physiological and social reasons, and sex workers are far more likely than the population at large to be infected. But the sexual behaviour of men is largely responsible for spreading the disease.

More than 60 million people have been infected with HIV, and AIDS has already killed more than 20 million people, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO.[1] In sub-Saharan Africa alone, 3.5 million were newly infected in 2001.

An estimated 40 million people are living with the virus, over 28 million in Africa and almost 95 per cent in developing countries. It is spreading most rapidly now in Eastern Europe and Central Asia, where most new infections are among injecting drug users.[2] India may have more than 4 million infected. Its prevalence in China is unknown, but it may be far more than the official estimate of about a million. Some estimates are as high as 6 million, with a possible 10 million by the end of the decade.[3]

HIV can also be passed *in utero* from infected mothers to their children. About a third of infected mothers pass the disease to their children in this way.

UNAIDS and WHO now estimate that more than 4 million children under the age of 15 have been infected with HIV. Over 90 per cent were infants born to HIV-positive mothers and acquired the virus before or during birth or through breastfeeding.

These infections have resulted in an unprecedented increase in infant mortality, because HIV infection progresses quickly to AIDS in children and many of these children have died. Of the 580,000 children under the age of 15 who died of AIDS in 2001, 500,000—nearly nine out of ten—were African.[4]

Half of new HIV infections are among young people aged 15-24, many of whom have no information or prevention services and are still ignorant about the epidemic and how to protect themselves. In studies of sexually active 15-19 year-olds in seven African countries, at least 40 per cent did not believe that they were at risk. In one country the figure was 87 per cent. At least 30 per cent of young people in 22 countries surveyed recently by UNICEF had never heard of AIDS; in 17 countries surveyed, over half of adolescents could not name a single method of protecting themselves against HIV. In all surveys, young women know less than young men, though young women are more vulnerable to infection.[5]

In developing countries HIV/AIDS is destroying lives and livelihoods alike, wiping out decades of progress. Even in the industrial countries most infections are among the poor. No developed country has an AIDS epidemic even approaching those of the poor world.[6]

"Economic and social changes ... have created an enabling environment that places tens of millions of people at risk of HIV infection."[7] Initiatives that only "seek to change behaviour are insufficient to stem the epidemic. Determinants of the epidemic go far beyond individual volition." We will not stop the pandemic by treating it only as a disease. HIV/AIDS accompanies poverty, is spread by poverty and produces poverty in its turn.

The relationship between poverty and HIV transmission is not simple. If it were, South Africa might not have Africa's largest epidemic, for South Africa is rich by African standards. Botswana is also relatively rich, yet this country has the highest levels of infection in the world. While most people with HIV/AIDS are poor, many others are infected.

Poverty's companions encourage the infection: undernourishment; lack of clean water, sanitation and hygienic living conditions; generally low levels of health, compromised immune systems, high incidence of other infections, including genital infections, and exposure to diseases such as tuberculosis and malaria; inadequate public health services; illiteracy and ignorance; pressures encouraging high-risk behaviour, from labour migration to alcohol abuse and gender violence; an inadequate leadership response to either HIV/AIDS or the problems of the poor; and finally, lack of confidence or hope for the future.[8]

Individuals, households and communities living with HIV/AIDS find that lost earnings, lost crops and missing treatment make them weaker, make their poverty deeper and push the vulnerable into poverty. The cycle intensifies.

Inequality sharpens the impact of poverty, and a mixture of poverty and inequality may be driving the epidemic. A South African truck driver is not well paid compared to the executives who run his company, but he is rich in comparison to the people in the rural areas he drives through. For the woman at a truck stop, a man with 50 rand ($10) is wealthy; her desperate need for money to feed her family may buy him unprotected sex, although she knows the risks.

Devastating Impacts

By 2010, about 40 million children worldwide will have been orphaned by the pandemic. The death of young working adults and the increase in widows, widowers and orphans will increase dependency as well as poverty. AIDS has already become the major cause of adult deaths in Africa, and projections suggest that increased deaths, fewer births and reduced fertility will slow or even reverse population growth. Life expectancy is falling, and has already fallen by 10 to 15 years in some countries. Sub-Saharan Africa will have 71 million fewer people by 2010 than it would have had without AIDS. The result is to threaten the economies, social structures and political stability of entire societies.[9]

HEALTH SERVICES DRAINED In most of Africa, malaria, tuberculosis and, increasingly, HIV/AIDS overwhelmed the health care system in the 1990s, at the same time as structural adjustment programmes forced governments to cut already meagre health budgets and shift much of the cost of care from the state to individuals. The result was to deprive many Africans of any health care at all.[10]

At the same time there has been a startling increase in the incidence of HIV/AIDS among health workers; Malawi and Zambia, for instance, report five- to six-fold increases in health worker illness and death rates. This leaves a decimated staff, struggling to overcome stress, overwork and fear, to confront an exploding crisis. The costs of new safety procedures and of lost time and labour has made health care scarcer and more expensive, placing it beyond the reach of many of the infected and leaving untrained household members—often older people—to care for sufferers at home.

Differentials in health services and access to affordable HIV/AIDS treatment determine survival rates and divide rich and poor countries and communities. As the struggle to reduce drug prices and expand treatment continues, public health services will determine the ability of households and communities to deal with the epidemic. Failure to provide health services, whatever the difficulties of meeting the short-term costs, will spell disaster for development and poverty eradication efforts.[11]

EDUCATION SYSTEMS COLLAPSING Education helps individuals protect themselves against HIV infection. In Zambia, for instance, surveillance data for Lusaka show that the HIV prevalence rate for women aged 15-19 dropped from 27 per cent in 1993 to 15 per cent in 1998, and that the decline was greater among those with secondary and higher levels of education. In the absence of a medical vaccine against HIV infection, education can provide a "social vaccine".[12]

AIDS is depriving children of their education. HIV/AIDS is killing teachers and administrators, draining education of its quality, increasing costs and weakening demand. Children who lose both parents to the epidemic are much less likely to continue attending school.[13] Girls are far more likely than boys to be kept at home to care for sick relatives, or to do housework to free older women for nursing. Children may become the household's only breadwinners if working-age adults are sick and others are too old or young to work.

In the Central African Republic, 85 per cent of teachers who died between 1996 and 1998 were HIV-positive, and they died on average ten years before they were due to retire.[14] In Kenya, the death toll among teachers rose from 450 in 1995 to 1,400 in 1999. Côte d'Ivoire and Malawi lose at least one teacher a day.

A recent forum in Cameroon estimated that 10 per cent of teachers and 20 per cent of students could be infected with HIV in the next five years.[15] The forum called for challenges to ignorance, secrecy, denial and the fear of stigmatization and discrimination that still pervade schools and colleges. Participants wanted HIV/AIDS education in schools, despite taboos and cultural obstacles.

Other recent proposals have included public subsidies to schools or directly to households in poor or heavily affected areas, to reduce education costs and keep children in school. If schools can be kept open and functioning, with a zero level of tolerance of sexual abuse, they can become focal points for strengthening the wider community response to AIDS and for providing participatory leadership within the community.

ECONOMIC IMPACTS HIV/AIDS is already slowing economic growth and activity in the worst-affected countries. It is estimated that in the 1990s AIDS reduced Africa's per capita annual growth by 0.8 per cent. Models suggest that in the worst-affected countries 1-2 percentage points will be sliced off per capita growth in coming years. This means that after two decades, many economies will be about 20-40 per cent smaller than they would have been in the absence of AIDS.[16] At the same time, HIV/AIDS calls for additional public resources to organize prevention efforts, provide treatment, maintain other health services, and care for orphans and other dependents.

Sick people work less effectively and are often absent. Their deaths, apart from the human tragedy, disrupt the workplace, reduce productivity, annul investment in training and impose the need to train replacements. Businesses cannot plan for an uncertain future.

AIDS-related sickness and deaths follow the HIV infection curve with a lag of several years, so HIV prevalence can be used to project the number of future illnesses, deaths and orphans. Data are less than perfect, but the epidemic is now old enough to be showing significant costs.[17] In April 2002, one of South Africa's major mining corporations, GoldFields, estimated that the HIV/AIDS epidemic would add up to $10 an ounce in gold production costs.

Many enterprises have tried to shift the burden by reducing benefits, shifting labour to temporary status and seeking to place the burdens of care and retraining on the state. But this strategy is ultimately self-defeating, because governments must tax the private sector to pay their costs.

In addition, it is clear that governments face exactly the same kind of problems. Staff are falling ill and dying: there are fewer teachers in the schools, police on the beat, nurses in the clinics and sanitation workers picking up garbage. Without experienced staff, government at all levels will break down, threatening not only economic development, but infrastructure like roads and airports, mechanisms such as law enforcement and taxation, and eventually social cohesion itself.

Damage in the rural sector is equally bad: family farms in Zimbabwe see a 40-60 per cent fall in the production of maize, peanuts and cotton after an AIDS death.[18] Not only income is lost: nutritious leafy crops and fruits are replaced by starchy root crops which require less labour; livestock may be sold to pay for medicine, leaving no source of nutritious foods like milk, meat or eggs. These changes bring on chronic food insecurity and high levels of protein malnutrition, which further compromise immune systems and open the path to infection.

Priorities for Action

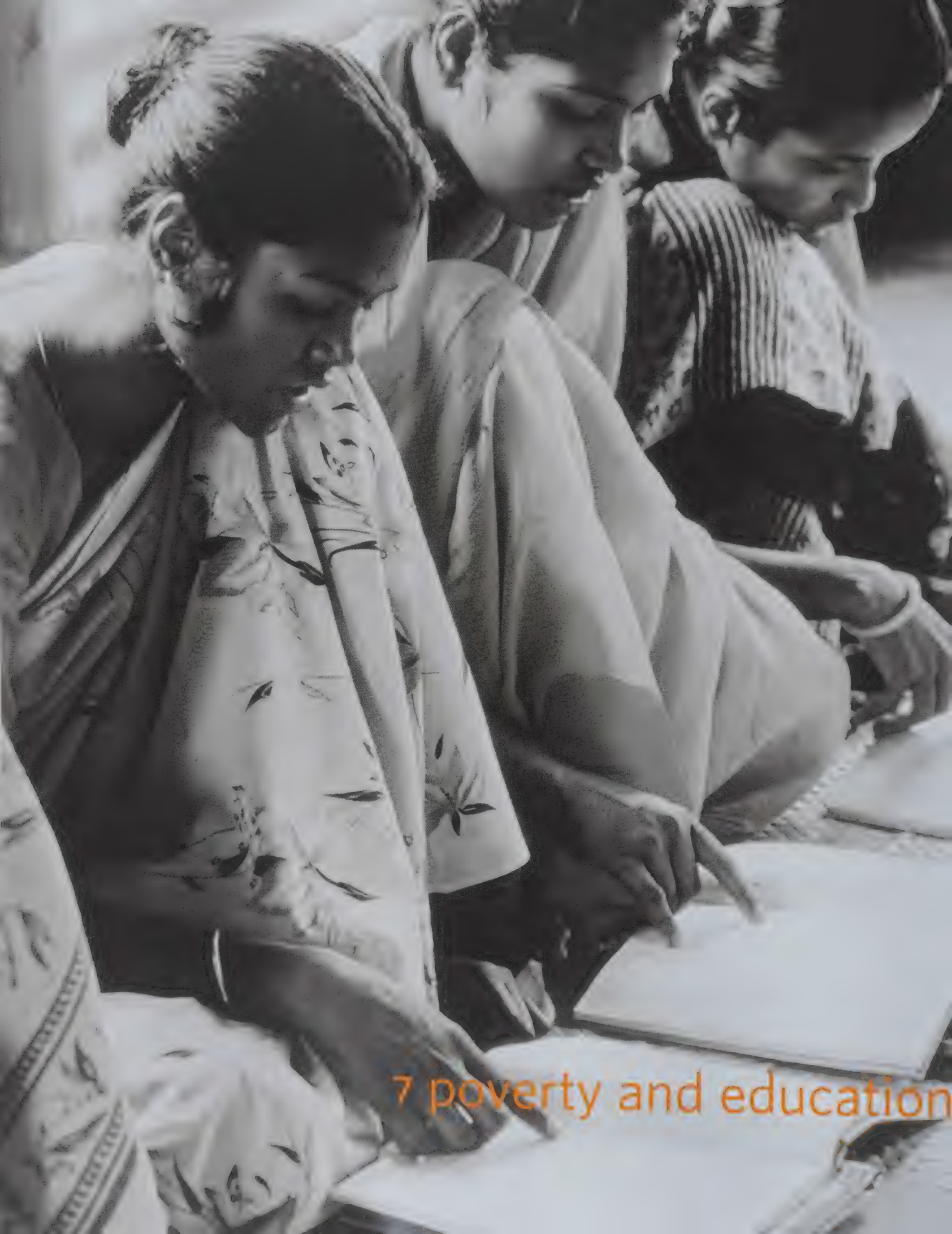
The poor have little access to prevention services such as condoms or any form of treatment. Only about one in five people at risk for HIV have access to prevention information and services.[19] Fewer than 5 per cent of people who need them get anti-retroviral drugs.[20] Action against the epidemic has been impeded by the slowness of leadership, at all levels, to recognize and admit the nature of the advancing crisis. The universal culture of silence that surrounds sexual behaviour has kept eyes averted and voices silenced.

In June 2001, a UN General Assembly Special Session on AIDS focused global attention on the crisis. UN Secretary-General Kofi Annan used an African Summit on HIV/AIDS and Other Infectious Diseases, convened in Abuja, Nigeria, in April 2001, to issue a call for action and propose a Global Fund to Fight AIDS, Tuberculosis and Malaria. The aim of this fund is to increase support for AIDS and related malaria and tuberculosis programmes in developing countries from under $2 billion annually to $7-10 billion.

The Global Fund announced its first round of grants for treatment and prevention in April 2002, awarding a total of $378 million over two years to 40 programmes in 31 countries. This important advance also highlights the continuing failure of the international community to meet the needs of the developing world. Funds contributed in the first year fell painfully short of the target.

Effective strategies to turn back the epidemic involve a combination of treatment, education and prevention. Such strategies must go beyond medicine and health care and reach into the community. They call for close consultation with the people they seek to assist.[21] Strong and committed leadership that leads by example as well as exhortation is a prime necessity.

The examples of imaginative, courageous local efforts in Senegal, Thailand and Uganda to mitigate the pandemic provide good news from around the world. Strong leadership can support and strengthen such community action.



7 poverty and education

Although overall access to basic education has risen substantially over the last decade in many developing countries, the poor are still less likely ever to attend school, less likely to be currently attending school, and more likely to repeat grades than those who are wealthier.

Education patterns among the poor differ distinctly by region. In South Asia and in West and Central Africa, a large minority of children from poor households never enrol in school. In Latin America, in contrast, virtually all children complete the first grade, but subsequent dropout rates are high. For example, 92 per cent of 15 to 19 year olds from poor households in Brazil complete first grade, but only half complete grade five. In other developing regions the pattern among the poor is characterized by higher proportions ever enrolling and later dropout.[1]

Wealth Differentials in Access and Attainment

There are wealth differences in school enrolment and attainment in virtually all developing countries, but the gaps wary widely across countries. Children aged 6-14 from the wealthiest 20 per cent of households are substantially more likely to be enrolled in school than children from the poorest 40 per cent of households in almost all countries.

The differences between rich and poor are particularly large (more than 45 percentage points) in several West African countries—Benin, Burkina Faso, Mali, Senegal—and in Morocco and Pakistan. In contrast, small differences are seen in Kenya, Malawi, Kazakhstan, and Uzbekistan.

Measures of school attainment also demonstrate wealth gaps that vary across countries. For example, in India the gap (in this case in the median number of years of schooling attained among 15-to-19-year-olds) between the richest 20 per cent and poorest 40 per cent is 10 years, whereas in Tanzania it is only two years.[2]

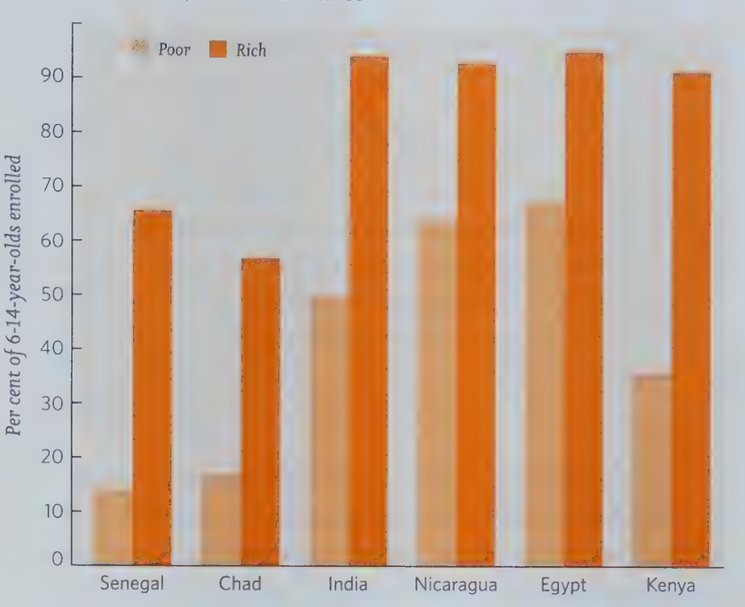
In many countries, most children from the poorest households have no schooling. A recent study of 35 countries in West and Central Africa and in South Asia showed that, in 10 countries, half or more of 15-19 year olds from poor households never completed grade one.[3]

There is longstanding international agreement that primary education should be universal by early in the 21st century. The gaps in educational attendance and attainment according to wealth imply that the poor are much farther away from achieving this goal than others.

Many countries would reach the goal by raising enrolment among the poor. For example, in Colombia, Peru and the Philippines, over 70 per cent of the shortfall in universal primary education is attributable to poor children.[4] There are only a few developing countries in which the rich have not already achieved universal primary education (see Figure 11).

REASONS FOR THE GAP Why are enrolment rates lower and educational outcomes worse among the poor? Both supply and demand are at work. First, it is harder for poor children to reach a school. Schools tend to be concentrated in cities and areas where wealthier households reside. For example, in Guinea, the average travel time

Figure 11: Wealth disparities in school enrolment
Per cent of children aged 6-14 enrolled in school in poorest and richest 20 per cent of households, selected countries



to the nearest primary school is 47 minutes in rural areas but only 19 minutes in urban areas.[5]

But the physical availability of schools is not the central issue in most countries.[6] Expenditures on education have increased over the last few decades in many places, but increases in spending without special attention to the needs of the poor can reinforce wealth disparities rather than reduce them.

The evidence from a range of developing countries suggests that a larger percentage of public spending on education goes to government actions that benefit the wealthy.[7] In Latin America, attainment disparities have been attributed to ineffective public school systems, upon which the poor depend, and a relatively low proportion of spending on primary and secondary education, the type of schooling that tends to benefit the poor most.[8] Even when governments direct sufficient resources to improving access to and quality of education among the poor, they may lack the administrative capacity to deliver services.

Crises such as war, civil conflict, economic collapse and epidemics disrupt services and hold back school attendance. In the former Yugoslavia and Central Asia, enrolment rates for basic education were far lower at the end of the 1990s than at the beginning. These problems are likely to have a greater effect on the poor than the non-poor.[9]

The quality of schooling—including curricula, textbooks, teaching methods, teacher training, pupil-teacher ratios and parental participation—helps determine educational outcomes, including school retention, attainment levels and test scores.[10] For example, recent research in South Africa shows that pupil-teacher ratio has a significant effect on the number of years of completed education.[11] In Egypt, dropout rates are related to a variety of elements of school quality and the learning environment. Boys and girls respond to different elements of the school environment.[12]

21 **FOOD FOR EDUCATION** Bangladesh's Food for Education Programme is a government initiative addressing household food insecurity and low female education among the poorest families. Launched in 1993, the programme covers about 5,000 primary schools all over the country. It supplies a food ration (wheat) replacing children's contribution to family livelihood and releasing them to go to school.

Attendance has increased for both boys and girls, but about 10-15 per cent more for girls. Besides the effect of education on empowerment, there is some evidence that it has led to delayed marriage, with important implications for women's life opportunities.

In some countries, declining fertility is reducing the pressure on public school systems, providing an opportunity to increase quality without necessarily increasing expenditures.

DEMAND AND EXPECTED BENEFITS Demand for education depends on perceived returns to the family, mainly anticipated income for educated children (but also better health and lower fertility).[13] One study estimates that, when opportunities are available for educated workers, earnings can increase on average by 10 per cent for each additional year of schooling.[14]

In some countries, the expected return from education is lower for a variety of reasons, lowering the demand for education among the poor. In Latin America, these factors include the cost of education, the low quality of public schooling, and discrimination against some ethnic or linguistic groups and against women in the labour market.[15]

In contrast, returns to education in East Asia and in some countries in South Asia have remained high because of investments in physical capital, improvements in technology, and pro-export and other beneficial trade policies, as well as support for education handed down within families.[16]

Programmes that reduce the cost of education for the poor can raise demand. For example, the PROGRESA programme in Mexico, which provides subsidies to poor families contingent on their children's regular attendance at school, has reduced dropout rates and improved grade progression.[17]

The Gender Gap

While the "gender gap" in education has narrowed over the last decade, the relative disadvantage still keeps girls from enrolment in secondary education in most of South Asia, sub-Saharan Africa and several other developing regions. About 31 per cent of women were without any formal education in 2000, compared to 18 per cent of men.[18] There are large variations among countries, with the widest gaps in North Africa and the narrowest in South Asia, Latin America and Central Asia.

Enrolment rates show the concentration of gender differentials in a few regions. South Asia and some countries in West Africa (Benin, Central African Republic and Chad) and Morocco have enrolment rates 15 or more percentage points higher for boys than girls. In several Latin American countries and in the Philippines, enrolment rates for girls aged 6-14 exceed those for boys.

The gender gap is typically wider at higher levels of schooling. Women in South Asia have only half as many years of education as men, and female enrolment rates at the secondary level are only two thirds of male rates. In sub-Saharan Africa, girls' school attendance at age 12-13 is 80 per cent that of boys but by age 18-19, only half as many girls as boys are attending school.[19]

Investing in education is critical for the future. If enrolment rates remain constant and fertility and mortality decline according to expected trends, there will still be a gender gap in educational attainment in 2030.[20] (It would not close completely even if enrolment rates in all countries rose to current North American levels by 2030, because of the wide gap among older age groups.[21])

CONTRIBUTING FACTORS The distance to school can be important in deciding whether girls attend because of family fears of sexual harassment on the way there. In Pakistan, where there is strict segregation of the sexes in school, the availability of schools has been found to affect schooling decisions for girls but not boys.[22]

School facilities and attitudes towards girls in school can be important, both for the girls and their parents. A study in Kenya found inadequate toilet facilities in many schools. Girls were harassed, and were more likely than boys to be assigned menial tasks.[23] If the quality of schooling is perceived to be low, parents may decide that girls can be more use at home. The cost of school fees, books and uniforms also works against girls more than boys, especially in poor families. In sub-Saharan Africa, girls are sometimes vulnerable to "sugar daddies" who offer to pay school fees in exchange for sex.[24]

Gender disparities within countries are often greater among the poor,[25] and in some countries continue among the poor after they have disappeared in wealthier groups,[26] so to be a girl from a poor family is a double disadvantage. Poor parents may be unwilling to educate girls because they believe that girls will never earn as much boys. Their labour is needed immediately to support the family,[27] help with household chores or care for younger siblings.

Poor communities where women's role is limited often do not believe that a girl needs formal education to be a wife and mother. Schooling is seen as attracting better-educated and financially successful husbands,[28] but parents expect the benefits of education will go to the husband's family, not their own.

Pregnancy can also lead to girls dropping out of school. Poor families with many children may withdraw daughters from school to help with child care. A lack of resources for school fees may force allocation choices that favour boys. School policies often compel pregnant girls to leave school; others leave due to marriage (though many girls leave at younger ages). The contribution of fertility to school discontinuation varies, but can be important.[29] A review of several country studies in sub-Saharan Africa found that between 8 and 25 per cent of girls' school discontinuation was due to pregnancy.[30]

CHALLENGES TO INVESTING IN GIRLS' EDUCATION Some experts believe it is wiser to invest in expanding and improving education for all children than to target resources towards girls, which they argue may reduce those available for boys. Another view is that programmes designed for girls' needs are required to get them into the classroom and stay there; and that investments that lower obstacles for girls also lower them for boys. Still others take the position that "child-centred" schools, regardless of the sex of the students, will work best.[31] Each perspective is being implemented and evaluated in different countries.

Another policy issue is whether to concentrate on educating girls or to include reducing illiteracy among adult women. Women manage their children's health and schooling, so educating them multiplies the value of investment in education. But some argue that scarce resources should be concentrated where they will have the greatest long-term effect.

Gender bias—in curricula, approaches to teaching, and the overall school environment—is an important policy concern. Girls may receive less attention from teachers, be perceived as less smart, and perform worse academically. This may be because the competitive and confrontational teaching style prevalent in many schools is inconsistent with traditionally valued female traits of passivity and collaboration. Educational materials typically display strong role models for boys but few or weak role models for girls. Girls are often not encouraged to take courses in technical and science fields that may enhance job opportunities, reinforcing gender segregation in the job market.[32]

Returns on Education Investments for the Poor

IMPACT OF PARENTS' EDUCATION ON CHILDREN'S EDUCATION Many studies have shown that the education of parents is linked to their children's educational attainment, and that the mother's education is usually more influential than the father's.[33] An educated mother's greater influence in household negotiations may allow her to secure more resources for her children. Educated mothers are more likely to be in the labour force, allowing them to pay some of the costs of schooling, and may be more aware of returns to schooling. And educated mothers, averaging fewer children, can concentrate more attention on each child.

Besides having fewer children, mothers with schooling are less likely to have mistimed or unwanted births. This has implications for schooling, because poor parents often must choose which of their children to educate. Having many siblings can reduce a child's educational chances if costs are involved,[34] though in sub-Saharan Africa extended family networks reduce this effect by spreading the cost among their members.[35] In a few countries, unintended children have significantly lower educational attainment than intended children.[36]

IMPACT ON REPRODUCTIVE AND CHILD HEALTH A great deal of evidence documents the benefits of schooling, particularly women's schooling, for health and nutrition, child survival, and lower fertility. For example, immunization rates among children of educated mothers are consistently higher than those of uneducated mothers, even after controlling for other associated factors.[37] Gains in women's education account for an estimated 43 per cent of the reduction in child malnutrition between 1970 and 1995, more than any other factor.[38] And the nutritional status of children is, in turn, linked to their cognitive achievement and early school enrolment.[39]

The causal pathways that link schooling to reproductive and child health outcomes have not been firmly established, but there is little doubt that education encourages women and enables them to understand and use information, to incorporate norms, and to make choices that lead to better outcomes for themselves and their children.[40]

Education is also strongly linked to better reproductive health for women. Numerous studies have shown that educated women are more likely to have adequate prenatal care, to have skilled

22 LITERACY FOR THE INDIGENOUS POOR Seventy per cent of the indigenous women in Bolivia's Chuquisaca and Potosi departments are illiterate. Women in the poor, rural region also suffer the country's highest maternal mortality rates.

An innovative UNFPA-supported project addresses both issues, by providing simultaneous literacy training in the indigenous Quechua language and Spanish, and information on reproductive health, health insurance and safe motherhood.

Between 1999 and 2002, over 100,000 women and men learned to read and write. A technical team trained more than 100 trainers, who in turn trained 3,500 literacy teachers. Each taught classes of 25 people, three times a week for eight months. Men and women met separately, to ensure that all could speak freely.

"I have learned how to keep myself and my house clean, how to plan with my husband how many children we are going to have, to have a good pregnancy check-up and to go to the health centre for check-ups," said one participant. "I wish we had been taught this before so we wouldn't have had so many children."

The project, implemented by the Vice Ministry of Alternative Education and funded by the United Nations Foundation, was promoted through local events, radio, and community groups. Activities were coordinated with local NGOs. In 2000, it was awarded UNESCO's Malcolm Adiseshiah Literacy Prize.

Participants have learned about the availability of lifesaving health services. In one project area, the number of attended deliveries doubled in two years as a result.

"In the past, we didn't know about these things," said Modesta Hinojosa. "We walked around with our big bellies herding the sheep, planting with our husbands, carrying the babies. There weren't any health centres, the women died and nobody said anything. Thank God we are now better informed and we will look after our health better."

assistance at the delivery of their babies, and to use contraception to avoid unwanted and mistimed births. Educated women also tend to initiate sexual activity later, to marry later, begin childbearing later, and to have fewer children than uneducated women.[41] The relationship between education and such life cycle events is reciprocal; girls who marry and have children early are unlikely to be in school while those in school are less likely to start a family.

Men's education tends to have less influence than women's education on reproductive health and family formation patterns in many countries, but its effects are generally positive. They reinforce the effects of women's education rather than substitute for them.[42]

ECONOMIC RETURNS Investments in the education and health of the poor yield returns in productivity, income and economic growth. Anti-poverty programmes in different arenas interact. Better education leads to better health and higher incomes among workers; improving workers' health increases their earning potential.

Strong and consistent evidence shows that a country's level of education has a positive effect on economic growth. And inequality in the distribution of education holds back growth, whatever the absolute level of education.[43] Educational inequality also holds down per capita income in many countries.[44] The economic policy environment affects this relationship: investments in education have a greater impact on growth in economies that provide greater prospects for workers to use their education and skills.

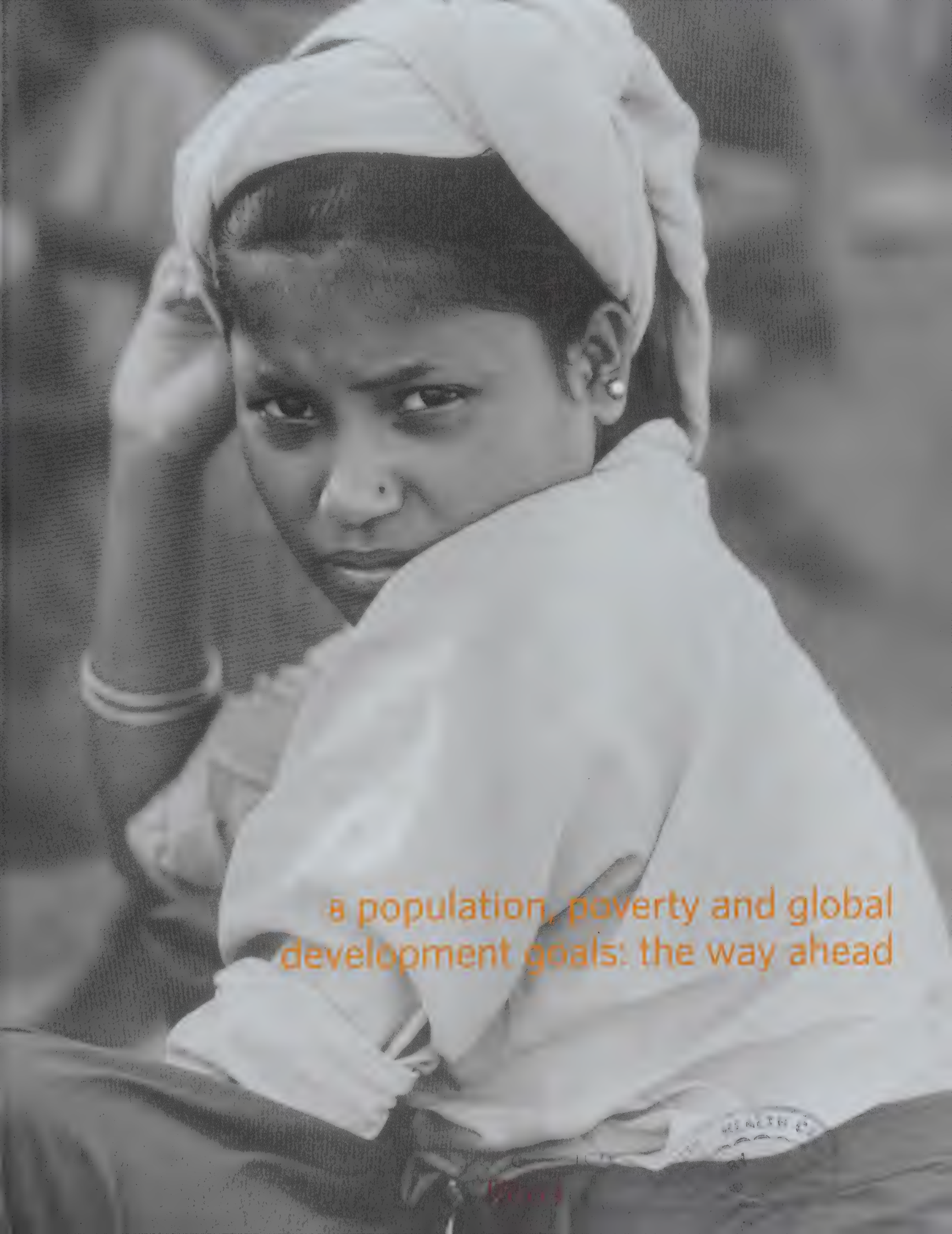
Households with low education are highly vulnerable to ill health and disability, price and credit swings, and natural and environmental disasters. Education helps to buffer such shocks by enabling more secure employment, higher incomes, and better access to economic assets and credit. The educated are generally more healthy than the uneducated, even those with similar incomes.[45]

Meeting the Goals of the ICPD

One focus of the International Conference on Population and Development in Cairo in 1994 was the promotion of educational opportunities, especially for women, as a means to promote social and economic development. Universal completion of primary education was set as a 20-year goal, as was wider access to secondary and higher education among girls and women.

Following the conference, many governments and NGOs made additional efforts to expand educational access for poor, particularly poor women. Programmes have included school fee subsidies, waivers, and vouchers, promotion of parental and community participation, and experiments with the expansion of private sector provision. And education is increasingly linked to programmes in the health and economic sectors as recognition of their intrinsic relationship grows.

At the fifth-year review of progress since the ICPD, new education goals were set: access to universal primary education by 2015, an increase in primary school enrolments to at least 90 per cent for both boys and girls by 2010, and a reduction by half of the 1990 illiteracy rate for women and girls by 2005. Renewed efforts at both the international and national level will be needed to achieve these goals. Special attention must be paid to the poor.



8 population, poverty and global development goals: the way ahead

Framework

THE DEVELOPMENT AGENDA: DEFEAT POVERTY Follow-up to the Millennium Summit in 2000 has concentrated the efforts of the international community and the United Nations system on ending poverty. The Millennium Development Goals include most of the goals agreed in 1994 at the International Conference on Population and Development and subsequent conferences—including better health, increased life expectancy, prevention of HIV/AIDS, universal basic education, and reductions in maternal, infant and child mortality.

The Millennium Declaration process recognized the importance of the development goals and indicators adopted at previous global conferences and is striving for harmonized national strategies for implementation.

GOALS OF THE ICPD AND QUANTITATIVE BENCHMARKS

The ICPD endorsed a set of interdependent population and development objectives, including sustained economic growth in the context of sustainable development, and gender equity and equality. Countries were urged to include population factors in all development strategies, and to act to eliminate gender-based violence and harmful traditional practices including female genital cutting.

Quantitative goals in three areas were adopted:

UNIVERSAL EDUCATION Elimination of the gender gap in primary and secondary education by 2005, and complete access to primary school or the equivalent by both girls and boys as quickly as possible and in any case before 2015;

The Millennium Summit accepted these targets and added elimination of gender disparities to all levels of education by 2015.[1]

MORTALITY REDUCTION Reduction in infant and under-5 mortality rates by at least one third, to no more than 50 and 70 per 1,000 live births, respectively, by 2000, and to below 35 and 45, respectively, by 2015; reduction in maternal mortality to half the 1990 levels by 2000 and by a further one half by 2015 (specifically, in countries with the highest levels of mortality, to below 60 per 100,000 live births);

The Millennium Summit simplified the under-5 mortality reduction (to one third of 1990 levels by 2015) and accepted the parallel three quarters reduction of maternal mortality.

REPRODUCTIVE HEALTH Provision of universal access to a full range of safe and reliable family planning methods and to related reproductive and sexual health services by 2015.

ICPD+5 The five-year review of ICPD in 1999 agreed on new benchmarks, which have been adopted in many nations:

- The 1990 illiteracy rate for women and girls should be halved by 2005. By 2010 the net primary school enrolment ratio for children of both sexes should be at least 90 per cent;
- By 2005, 60 per cent of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections including STIs, and barrier methods to prevent infection; 80 per cent of facilities should offer such services by 2010, and all should do so by 2015;
- At least 40 per cent of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80 per cent globally, by 2005; these figures should be 50 and 85 per cent, respectively, by 2010; and 60 and 90 per cent by 2015;
- Any gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, 75 per cent by 2010, and 100 per cent by 2015. Recruitment targets or quotas should not be used in attempting to reach this goal.

23 STATEMENTS BY THE COMMISSION ON MACRO-ECONOMICS AND HEALTH

"Investments in reproductive health, including family planning and access to contraceptives, are crucial accompaniments of investments in disease control. The combination of disease control and reproductive health is likely to translate into reduced fertility, greater investments in health and education of each child, and reduced population growth."

"If these conditions [communicable diseases] were controlled in conjunction with enhanced programmes of family planning, impoverished families could not only enjoy lives that are longer, healthier and more productive, but they would also choose to have fewer children, secure in the knowledge that their children would survive, and could thereby invest more in the education and health of each child. Given the special burdens of some of these conditions on women, the well-being of women would especially be improved."

"The evidence also suggests that approaches required to scale up the health system to provide interventions for communicable diseases and reproductive health will also improve care for the NCDs [non-communicable diseases]."

"Experience shows, moreover, that family planning services are most effective when they are a part of comprehensive programmes for reproductive health, that include family planning, safe pregnancy and delivery, and the prevention and treatment of reproductive tract infections and sexually transmitted diseases."

"Rapid population growth has multiple and complex effects on economic development. At the household level, investments per child in education and health are reduced when households have many children, that is, when fertility rates are high. At the societal level, rapid rural population growth in particular puts enormous stress on the physical environment (e.g., deforestation, as forests are cut for firewood and new farm land) and on food productivity as land-labour ratios in agriculture decline. Desperately poor peasants are then likely to crowd cities, leading to very high rates of urbanization, with additional adverse consequences in congestion and in declining urban capital per person (e.g., housing, services, water and sanitation, etc.)"

24 COOPERATING TO FIGHT POVERTY

The Millennium Summit was the start of an unprecedented effort of UN Member States to put political will behind core development goals and heightened cooperation.

The International Conference on Financing for Development in March 2002 endorsed recommendations on liberalizing trade, expanding private-sector involvement and directing debt relief. The European Union and the United States pledged to reverse the decline in official development assistance.

The Secretary-General will report annually to the General Assembly on progress towards the Millennium Development Goals. The 2002 report addressed armed conflict and the treatment and prevention of diseases including HIV/AIDS and malaria. A Global Millennium Project will address key thematic areas, using expertise within the UN community, academia, development assistance and finance institutions, and the private sector in developed and developing countries. The Global Millennium Campaign will mobilize public support for anti-poverty efforts and attainment of the MDGs.

The United Nations system has improved the coordination of its activities at the international, regional and national levels. The United Nations Development Group is coordinating policies of UN agencies and organizations. The Senior Management Group meets weekly and reviews policy issues. In May 2002, for example, it dedicated a session to population age structures and development priorities.

UNFPA serves on an interagency group formulating strategies for improved monitoring of progress. The Fund is coordinating efforts to improve data for national-level monitoring. Every developing country is expected to prepare at least one country report by the end of 2004. The technical task forces of the Global Millennium Project will incorporate population and reproductive health expertise supported by the Fund.

HIV/AIDS Recognizing that the HIV/AIDS situation is worse than anticipated by the ICPD, the ICPD+5 review agreed that to reduce vulnerability to HIV/AIDS infection, at least 90 per cent of young men and women aged 15 to 24 should have access by 2005 to preventive methods—such as female and male condoms, voluntary testing, counselling, and follow-up—and at least 95 per cent by 2010. HIV infection rates in persons 15 to 24 years of age should be reduced by 25 per cent in the most-affected countries by 2005, and by 25 per cent globally by 2010.

REPRODUCTIVE HEALTH AND THE MDGS Many of the Millennium Development Goals, including health goals, depend on the universal availability of family planning and other reproductive health choices, and on other issues related to population (see page 7).

In the area of health, the Secretary-General's 2002 report on progress towards the MDGs was strongly influenced by the work of the Commission on Macro-economics and Health, set up by WHO and the World Bank. Five different working groups spent two years on studies and consultations about priority interventions concerning the relation of health, and particularly the disease-related aspects of health, their costs and expected economic impact.

The Commission recognized that population and reproductive health are central to the attainment of the health goals of the Millennium Summit and to the entire development agenda.

The ICPD in 1994 emphasized the interconnectedness of population dynamics, the ability of individuals and couples to make reproductive choices, better health, development, and poverty reduction. The Commission shared this understanding, as excerpts from its report show (see box 23). National and international action plans for attainment of the Millennium Development Goals should reflect these understandings.

Recommendations for Action

COOPERATE FOR EFFECTIVENESS Governments, communities, the private sector and the international community must cooperate to make best use of their comparative advantages and reduce duplication, waste and inefficiency. This has been a common call for many years, but the battle against extreme poverty has given it new emphasis.

GOVERNMENTS' ROLE National action to improve the health of the poor and reduce health inequalities includes:

- economic policies that contribute to poverty decline;
- information on health and health services;
- control of infectious diseases;
- legislation for better health;
- subsidized health services for the poor;[2]

The World Health Report 2000 calls for governments to be better stewards of the public health and of health care resources, particularly to benefit the poor.[3]

Meeting the ICPD consensus goal of universal access to reproductive health care by 2015 requires safety net systems—free services, subsidized care, insurance schemes and sliding-scale fees—to ensure that the poor clients receive reproductive health care. "The ICPD agenda helps frame the issue of health financing in terms of client needs and empowerment. The question that needs to be asked by any policy initiative is, will it hurt the poor and will it discriminate against women?"[4]

NATIONAL POVERTY REDUCTION STRATEGY PAPERS The World Bank and the United Nations system, including UNFPA, are coordinating their assistance for development in the poorest countries. An important tool is the national Poverty Reduction Strategy

Paper (PRSP), which outlines national priorities and action plans following broad-based and participatory analyses led by government and national stakeholders, including civil society groups, parliamentarians and the private sector.

These plans are recognized as an important vehicle for progress towards the MDGs. Regularly reviewed, they will serve as the basis for implementation and monitoring. The plans can be the basis for debt relief under the Highly Indebted Countries Initiative for candidate countries, and for concessional lending in others.

Many countries have already developed papers preliminary to the broad exercise (called interim PRSPs) or completed their plans and started the continuous process of implementation, monitoring and revision.

Analyses of the process conclude that many of the plans being developed are analytically sound and practical. However, further improvements are needed to build national capacity and ensure fuller participation by a broad range of national stakeholders.[5] The participatory person-directed approach to development promulgated in the ICPD and other international conferences has advanced significantly in the past decade, but continued improvements will be required.

A UNFPA review of 44 interim PRSPs showed that improvements are also needed to ensure the fuller incorporation of population, reproductive health, gender equity and human rights concerns.[6] UNFPA will be giving higher priority to coordinated development, including PRSPs, health sector reform, sector-wide approaches and UN system Common Country Assessments, and in civil society outreach, in order to redress such omissions.

25 **LISTENING TO THE POOR ON HEALTH** A study for the *World Development Report* listened to the poor in 23 countries as they talked about the effect of poverty on their lives. Author Deepa Narayan offers five suggestions based on the study, *Consultations with the Poor*.

First, protect the poor against the financial shocks of ill health. Far too many poor people must choose between saving family members who are sick and feeding the rest. Design better ways to protect against catastrophic illness, building on the experiences of institutions like India's Self-Employed Women's Association and Bangladesh's Grameen Bank.

Second, provide effective health infrastructure where the poor live. Water and sanitation are particularly important, especially in South Asia where poor women are deeply fearful about having to go long distances for water.

Third, improve the behaviour of health care providers in public facilities. The rudeness of some government health care providers helps explain why the poor avoid government services.

Fourth, combat domestic, gender-based violence. The effects of violence on women are a public health concern.

Fifth, recognize the psychological as well as the physical impact of HIV/AIDS. Among the poor, especially in Africa AIDS means stigma and shame, as well as suffering

DIRECTING PROGRAMMES TO REACH THE POOR Closer attentio to poverty alleviation demands that programme benefits reach poo people directly.

The ICPD Programme of Action lists a number of good examples of services targeted directly to the poor. UNFPA has led interagency policy discussions on basic social services, acknowledging the social service orientation of the Programme of Action. Effective population and reproductive health programmes focus on individual service and information needs. The principles of service orientation are already well established in the area of reproductive health, but health services must also reach the poor with prevention and treatment of important communicable diseases.

Effective reproductive health programmes for the poor depend on listening to their opinions and involving them in programme design and delivery. This is especially important for women, who have the most to gain from population and reproductive health programmes.

It is not enough to steer technical and financial assistance to the poorest countries: programmes within countries must direct domestic and international resources to the poorest of the poor. They must have protection, support and a voice.

The basic principles are simple:

- target services to reach the poor;
- reduce costs to the poor;
- give the poor a voice in the design, implementation and monitoring of programmes;
- provide public assistance for public goods, including services with large indirect effects;
- stress prevention—it is cheaper than cure (often in both the long and short run);
- improve the quality of services;
- improve data that monitors what the poor need and what they get;
- advocate for programmes to reach the poor and improve the data used to provide services and mobilize needed resources and support;
- reduce inefficiencies and inequities.

Analysts identify four means of directing health resources to the poor:[7]

- **Address the burden of disease:** see that resources address health conditions for which the burden of disease is high among the poor;
- **Provide basic social services:** give priority to basic social services, primary health care, prevention and basic curative services plus health promotion and essential surgery;
- **Direct resources to poor areas:** provide attention to rural and poor peri-urban areas, remote populations and slums;
- **Direct resources to the poorest households and communities:** protect the poorest from a cost burden they cannot meet.

REPRODUCTIVE HEALTH ACCESS Better reproductive health is important to improving the health of poor people. Conditions related to reproductive health account for half of the top 10 causes of the disease burden among women of reproductive age. The burden is markedly higher among poorer and higher-fertility populations.

Of all income groups, the poor have the least access to reproductive health information and services and the greatest exposure to risk. The poor tend to want larger families than the better off, but they also have more unwanted and unintended pregnancy. High levels of unintended pregnancy result in even higher levels of actual fertility than desired. This increases the need for antenatal care and safe delivery services and for quality family planning services to reduce unwanted pregnancy and recourse to abortion.

Improving the quality of reproductive health services is the key to improving their accessibility and usefulness to poor people.[8] Officials often abuse or mistreat poor clients, who do not have the information or confidence to question their treatment or the price of service. Quality depends on a reliable supply of drugs and commodities, as well as on good training and supervision. Technical competence is important, and it is also important that staff respect users' personal dignity, respond to their questions and approach them as individuals with diverse needs and cultural backgrounds.

COMMUNITY PARTICIPATION Religious and charitable institutions, including places of worship, schools, hospitals, food delivery systems, hospices and teaching or pastoral care, often provide what services there are in poor communities, particularly where public services are absent or inaccessible.

The population and women's conferences in 1994 and 1995 called for increased community participation, and particularly for giving women and other marginalized groups—the very poor, adolescents and people living with AIDS—a voice in the community and in development activities. Strong civil society organizations can help this process.

Decentralizing health care can help community involvement, but for decentralization to benefit the poor, poor people themselves must be involved in setting priorities. Direct involvement of parents and community leaders is especially important for discussing and addressing adolescent reproductive health problems such as teenage pregnancy and HIV/AIDS prevention.

Advocates are working to ensure that reproductive health needs do not get lost in decentralized systems.[9] They have called for universal access by poor women to safe motherhood services, including emergency obstetric care, for example, and for equitable treatment of people living with AIDS. Community movements have sprung up to provide support for members affected by HIV/AIDS, particularly orphans, despite the stigma and discrimination associated with the disease. Community insurance and health support systems can help women especially to protect themselves from risks and gain access to needed services—for example emergency transport for pregnant women who have difficulties in labour. An active civil society can create a supportive environment for community action.[10]

MEETING SPECIAL NEEDS The ICPD Programme of Action called for better population and development programmes, while ensuring their accountability to the most vulnerable and disadvantaged groups in society, including the rural population and adolescents.[11] It stressed that population-related programmes contribute to the empowerment of women and improved health, especially in the rural areas, along with other benefits.[12] It called for particular emphasis on meeting the reproductive health needs of underserved population groups, including adolescents, "taking into account the rights and responsibilities of parents and the needs of adolescents and the rural and the urban poor".[13]

RURAL AND OTHER UNDERSERVED POPULATIONS Experience shows that poverty reduction depends on the success of rural development programmes.[14] Poor people in rural areas still have a higher level of unmet need for family planning services, and resulting unwanted fertility, than people in urban areas. This contributes to population pressures on local environments, driving migration to overcrowded cities and the areas around them.[15]

The five-year review of the Programme of Action encouraged countries to ensure that assistance from international donors is invested to maximize benefits to the poor and other vulnerable population groups.[16]

URBAN MIGRANTS Though cities overall have better social services than rural areas, urban slums and shanty towns are often neglected. So are medium-sized cities, which are growing relatively rapidly.[17] They provide local markets and services, and link the countryside to the larger agglomerations; yet they receive relatively little central support and lack the authority to raise funds through taxes and charges. Increased attention is being given to discovering where the poor are concentrated, in order to direct services, subsidies and other resources.

REFUGEES AND DISPLACED PERSONS Among the poorest of the poor are people driven from their homes by natural disaster, political upheaval, social strife and war. They often live in temporary camps where social services are minimal, and international assistance provides whatever help is available to meet immediate needs and plan for resettlement.

Three quarters of displaced and refugee populations are women and children. Twenty-five per cent are women of reproductive age. One in five is likely to be pregnant. They may have suffered rape or assault in their homes or as they fled. Sexual violence and exploitation in refugee camps is all too common. For these women, already suffering, childbirth is even more risky than it would be at home, unless some basic services are available. They may need counselling and psychological support.

Reproductive health services for populations in crisis take their place with food, shelter, water and physical safety. They save women's lives. They are essential for health and dignity in extreme situations.

UNFPA provides support in emergencies, focusing on:

- safe motherhood through clean delivery, family planning and emergency obstetric care;
- family planning information and services;
- prevention and treatment of reproductive tract infections and STIs;
- prevention of HIV/AIDS, including information on universal precautions;
- adolescent health;
- prevention and treatment of sexual and gender-based violence.[18]

ADOLESCENTS There are now more than 1 billion young people between the ages of 10 and 19 in developing countries, the largest such group in history. This age group is expected to become bigger at least through the middle of the century, increasing by another 174 million by 2050. These young people are the productive workers and the parents of the future—but they need information and skills to protect their lives and health and fulfil their potential.

At international meetings, young people repeatedly call for respect, encouragement and nurturing as they grow to adulthood. Young people have expressed their needs wherever and whenever they are given a chance—at regional meetings of adolescents[19] and at the United Nations Special Session on Children in May 2002 in New York.

Young people's access to reproductive health information and services has been restricted—even if they are married—and the topic has been extremely sensitive. But their needs can be met with appropriate and age-sensitive involvement of parents, families, friends, cultural leaders, communities and peers. Apart from formal schooling, young people need education which reflects the complexity of their lives, including livelihood training, entrepreneurship, negotiation skills, gender equity, health and nutrition—all aspects of preparing for adulthood.

MICROCREDIT Deep poverty reaches into all areas of life. Many needs interlock: health is a matter of housing, nutrition, clean water and sanitation as well as health services. Integrated approaches empower people to set their own courses out of poverty.

Microcredit schemes are among the most effective means to empower the poor, and particularly poor women, for economic and social advancement. The amounts of money lent are typically small usually less than $100. Group-based schemes encourage members to work together and support each other, and have become popular with donors partly because they have a very good track record in repayment. They often include other services such as literacy and family planning.

The Microcredit Summit of 1997 adopted the goal of extending credit for self-employment and other business services to the 100 million poorest families, and particularly to women. Special attention would be given to reaching the poorest in each country. In 2000, microcredit reached nearly 31 million clients, over 19 million in the poorest households and over 14 million of the poorest women.[20]

The International Microcredit Campaign has developed "tool kits" to measure household poverty and identify the poorest households. Tools include a Participatory Wealth Ranking that uses community informants to identify poor households and the CASHPOR House Index of a common set of household characteristics. Training and dissemination are increasing, particularly in Africa and Asia.

Micro-finance has showed women how to earn money, but there is still the question of who controls the resources they bring into the home. Male partnership is not guaranteed, and some men feel threatened by their wives' new earning power.

BETTER MONITORING AND DATA SYSTEMS The poorest countries need to improve data systems for monitoring progress towards the MDGs. UNFPA is working with partner institutions of the UN, the international financial institutions, bilateral donors and foundations to strengthen national monitoring capacity.

UNFPA has long experience in supporting population data collection. The Fund has moved from broad support for countries' first censuses to providing specialized technical assistance. In many low-income developing countries UNFPA acts as the coordinator of UN system support in the area. In 2000, Cambodia gave the UNFPA representative one of the nation's highest honours for

26 **MICROCREDIT, SOCIAL INSURANCE AND REPRODUCTIVE HEALTH** Several micro-finance programmes have included from their inception family planning, child nutrition and health and related activities. In Bangladesh, Grameen Bank, BRAC and other NGOs encourage their members to discuss and adopt family planning. *Pro Mujer* in Bolivia and schemes in other Latin American countries do the same.

Group-based insurance schemes often seek to provide social protection such as health insurance to their participants, subsidized from the returns on loans. Groups decide which services they need, depending on participant priorities and on the terms they can negotiate.

In francophone countries in western Africa there were 360 insurance and credit schemes by 2001, covering 1.25 million people, a seven-fold increase since their start in 1988. Increased coverage has improved their negotiating position.

One insurance group contracted with a service to teach mothers in the group how to stimulate cognitive ability in their children. One client, impressed by the intensity and duration of the suggested exercises concluded, "If we need to do all this work with our kids, we can't have more than two." The group subsequently added family planning services to its offerings.

Researchers attribute members increased use of modern family planning to better information and the mutual support that women give to each other's choices. Increased decision-making power within the family and changes in women's status take longer to develop.

assistance with its first census after decades of political instability.

UNFPA helps countries collect information to develop policy responses to emerging issues, for example the impact of the 1998 economic crisis on reproductive health in South East Asia, and the quality of life of older people in India and South Africa.

UNFPA has assisted censuses and surveys in refugee camps and other post-conflict settings. It has joined in UN system-wide support to census and statistical organizations in many emergency situations. It has encouraged qualitative research,[21] for example, studies of reproductive health, gender violence and related issues among internally displaced persons in Angola. UNFPA support helped establish and publicize the extent of rape and assaults on women in the former Yugoslavia during the wars of the 1990s, so that the women could get help. The Fund is assisting the development of data collection and data-based policy development in East Timor.

Demographic and Health Surveys funded by UNFPA and other donors are important for monitoring mortality, fertility, health, poverty and service access, and showing where improvements are needed.[22] They have provided practical methods to estimate wealth to help poverty-related policy research.[23]

IDENTIFY DATA NEEDS As programme staff, researchers, policy makers, NGOs and other users clarify their data needs, UNFPA will promote integrated approaches to assessment. For example, the Fund may suggest including key demographic and behavioural measures in economic and other surveys, improving the gender-sensitivity of data collection systems and indicators, and combining different measures in databases intended for policy makers.

With decentralization, municipalities or districts are making decisions about priorities in development plans and local health delivery. These local bodies need access to local data and training in its use to make evidence-based decisions on policies and programmes. UNFPA provides support to empower local decision makers and give them accurate and timely information on which to base decisions about priorities in reproductive health and gender empowerment.

They will use the improved data together with direct inputs from affected populations to target interventions and make financing decisions and formulate responsive strategies.

27 **LIMITATIONS OF THE DISABILITY ADJUSTED LIFE YEARS MEASURE** National health systems and decentralized health committees alike often base their decisions about what to offer in basic or essential service packages on measures that do not fully reflect the impact of reproductive health. The widely used Disability Adjusted Life Years (DALYs) measure, for example, estimates the impact of a disease or condition in terms of an individual's lost quality of life. However, various technical features of this measure underestimate the importance of reproductive health:

- The disease-oriented approach doesn't address conditions that affect life quality and health but are not diseases, for example unwanted pregnancy;
- The loss of mothers' lives from unsafe abortion is reflected in the measure, but not the public health implications of preventing unwanted pregnancy and abortion through safe and effective family planning;
- Less weight is given to lost health among people older than 25 than in younger groups, discounting health effects in most of the reproductive years (15-49);
- Impacts of a person's disease on other family members (on the children of an ill mother, for example) are not included;
- The experts who determined the severity of various conditions and the weights assigned to them were mostly from developed countries—where reproductive morbidity is less common—and included few women.

Census data make it possible to draw "poverty maps" on which poor neighbourhoods show up. This helps in placing service delivery points and outreach systems for the broadest possible coverage.[24]

In addition to improving data on demographic trends and quality of life, countries need better data on the benefits and costs of programmes, where the resources for them come from and how they can be more effectively used.

28 **EUROPEAN UNION DECLARATION ON HEALTH** In May 2002, following the United Nations Special Session on Children, the European Union Development Council reaffirmed its commitment to the continuing international consensus on priorities in assistance to health, stressing the importance of universal access to reproductive health services and rights.

"The EU reconfirms its firm commitment to contribute to ensuring that by 2015 the death rates for infants and children under the age of five years in developing countries is reduced by two thirds; the rate of maternal mortality is reduced by three quarters; universal access to reproductive health care and services is provided for all individuals of appropriate ages, consistent with the commitment and outcomes of the International Conference on Population and Development (ICPD) and other UN conferences and summits; the spread of HIV/AIDS and the incidence of malaria and other major diseases is halted and begins to be reversed."

The European Union further indicated that over the next five years, the EU will increase the volume of development assistance targeting improved health outcomes and will invite recipient countries and the international community to join them in filling the financing gap to meet the Millennium Development Goals. They emphasized that in supporting health programmes, particular attention will be paid to communicable diseases, maternal health and to reproductive and sexual health and rights.

Resources for Population and Reproductive Health

Since 1969, UNFPA has been the largest multilateral source of population assistance, providing some $6 billion for population programmes.

ICPD RESOURCE GOALS In 1994, at the International Conference on Population and Development, nations committed themselves to the goal of universal access to reproductive health by the year 2015.[25] The five-year review of the ICPD and subsequent international and regional conferences reaffirmed this goal.[26]

The goal remains a priority for the international community. It figures in the monitoring standards of bilateral assistance agencies (including the development agencies of the United States and the United Kingdom), the World Bank and the evolving efforts of developing countries.

As part of the ICPD consensus, the international community accepted expert estimates of the cost of a package of services towards the goal of universal access to reproductive health. The package included family planning; safe delivery; prevention of sexually transmitted diseases; other reproductive health services; and population data collection and analysis. These estimates were reaffirmed at the UN General Assembly's five-year review of ICPD implementation in 1999.

This commitment was directed to seeing that every pregnancy would be a wanted pregnancy and every child a wanted child, born with care assuring that both the mother and the baby would be healthy and free from sexually transmitted diseases.

Estimated needs were $17.0 billion a year in the year 2000. The requirement was projected to increase to $18.5 billion in 2005, $20.5 billion in 2010, and $21.7 billion in 2015. The international community was called on to provide one third of these amounts.

The services included in the package can be delivered through primary health care systems. Additional resources will be required for basic health infrastructure development, tertiary care, emergency obstetrical care, specialized HIV/AIDS prevention interventions,[27] and the treatment and care of those living with HIV/AIDS.

ADDITIONAL RESOURCES NEEDED Further resources are needed for other population-related development goals in the Programme of Action. Among these are:

- universal basic education;
- the empowerment of women;
- environmental concerns;
- employment generation;
- poverty eradication.

More detailed costing for the Millennium Development Goals will elaborate some of these additional requirements.

Some reproductive health needs were not fully foreseen in 1994, and call for additional resources. Among these are much broader and more urgent efforts to prevent HIV/AIDS infection; and expanded information, care and services for people in emergency situations.

PROGRESS IN MOBILIZING THE RESOURCES Donor countries are contributing less than a quarter of current expenditure towards the goal of universal access to reproductive health by 2015. Their commitment was one third of a much larger total.

At the ICPD, countries agreed that one third of the $17 billion annual requirement for basic reproductive health and population programmes in 2000, or $5.7 billion, was to come from the international community; two thirds, or $11.4 billion, was to be provided by developing countries and other countries needing assistance.

In the year 2000, total expenditure was $10.9 billion. Assistance totalled $2.6 billion. This is less than a quarter (24 per cent) of total expenditure, and less than half (46 per cent) of the commitment. Developing countries contributed $8.3 billion, 76 per cent of the total spent and about 73 per cent of their commitment. A few large countries account for much of this expenditure. Africa is the region with the largest share (70 per cent) of allocations coming from international sources.

BROADER FOCUS NEEDED The Millennium Summit adopted a disease-oriented approach to health. Issues such as unwanted pregnancy and family planning, which are not diseases, did not figure prominently in the Summit decisions, and thus not in the Millennium Development Goals.

The Commission on Macro-economics and Health[28] did not fully cost family planning, a key element in reproductive health, when estimating needs for essential health interventions. It included only the cost of family planning commodities, for one year after the birth of a child, though WHO standards suggest that the health gains for children and for mothers of spacing births 24 to 30 months apart are considerable.

Resources are therefore needed to ensure an adequate supply of temporary methods of contraception, such as condoms. The United Nations Population Division estimates for less-developed regions[29] indicate that over 100 million couples—over 20 per cent of all users—use temporary methods. IUD users, an additional 27 per cent, also need resupply, but at longer intervals.

The excellent foundation provided by the Commission can be further elaborated as the follow-up process continues, recognizing these additional needs and acknowledging the importance of universal access to reproductive health, including family planning, for reaching the Millennium Development Goals.[30]

NEW INVESTMENTS IN FAMILY PLANNING In the area of family planning, the necessary programme investments—all as part of strengthening health infrastructure—include:

- commodities and logistic systems;
- management and quality control;

- counselling and follow-up (including adjustments in method choice, if indicated);
- sociocultural research to address barriers to effective or proper use, and to facilitate introduction of new methods or options for service delivery;
- introduction of both cost-sharing and equity systems;
- establishing appropriate public-private partnerships;
- operations research and contraceptive development.

Research is needed on effective, user-friendly and culturally acceptable methods of family planning, especially those a woman herself can control. Preventing sexually transmitted diseases, including HIV/AIDS, calls for additional investment in contraceptives that are also microbicides.

This should be part of the response to the Commission's call for "a significant scaling up of financing for global R&D [research and development] on the heavy disease burdens of the poor ...."[31] Contraceptive development, supply, logistics and management should also be included in the estimates of capital and recurrent investments needed.

Investing for Health, Fighting Poverty

Providing reproductive health services, including family planning, offers clear and direct benefits for empowering women, improving lives, and reducing poverty:

- Better prenatal and delivery services help mothers go through pregnancy safely and children survive the risky first years of life;
- Reducing sexually transmitted diseases improves adult survival rates and spares men and women from suffering;
- Fewer unwanted pregnancies improves women's health;
- Spaced births and fewer pregnancies overall improves child survival; for women it means more time with each child, and more opportunity for employment and other options.

Having fewer young dependents compared to the working-age population helps families escape from poverty. It opens a demographic window, an opportunity for countries to achieve faster economic growth.

Continued progress depends on continued investment, domestic and international.[32]

Decades of social and economic research show that reproductive health programmes, including family planning, are among the most cost-effective health and social development programmes. The World Bank included family planning and other reproductive health programmes among its set of highest-priority health interventions in its seminal 1993 *World Development Report: Investing in Health*.[33]

There are no agreed methodologies for estimating the ratio of costs to benefits—both are hard to calculate with certainty—but benefits are there to be seen. This report has outlined the depth and diversity of gains to be expected. Confining the benefits to the health sector, the benefits in savings from averted illness alone are significantly greater than the cost of the services.[34]

Rigorous methodologies for estimating more-distant effects can also demonstrate powerful returns to reproductive health investments. The environmental benefits of avoiding unwanted births—through lower resource consumption and greenhouse gas emissions, for example—far outweigh the costs.[35]

COMPARING APPROACHES Among reproductive health interventions, the cost-effectiveness of different approaches to solving a single problem can be compared.

In HIV/AIDS prevention, for example, the focus of UNFPA's work against the pandemic, is 28 times more cost-effective than highly active antiretroviral therapy (HAART).[36] Of course, a comprehensive approach to HIV/AIDS recognizes the synergies between prevention and treatment: HAART for example reduces the viral load, making transmission less likely. Balance will also be needed between efforts addressing health impacts and those affecting the social and institutional contexts that place people at risk.[37] Countries need national strategies and institutions with particular comparative advantages and strategic strengths.

INTERACTION OF BENEFITS AND COSTS Integrated service delivery has long been recognized, notably in the ICPD Programme of Action, as both cost-effective and most likely to ensure a client-centred approach to health. The Commission on Macro-economics and Health recognized this professional consensus in promoting the "Close-To-Client" service system.[38]

29 **REPRODUCTIVE HEALTH ESSENTIALS** UNFPA is coordinating an initiative to ensure the reliable supply of reproductive health essentials. This programme is designed to provide high-quality commodities to developing countries at the lowest possible negotiated price.

Demand for modern contraceptives will increase by over 40 per cent during the next 15 years as the result of unmet need, increased demand and growing populations of reproductive ages.

Only 53 per cent of births are attended by trained practitioners, and access to emergency obstetric care is extremely low, particularly among poor and rural women. To save women's lives, there must be a large increase in essential equipment and medications for safe delivery.

UNFPA estimates that contraceptive requirements for family planning and prevention of STIs and HIV/AIDS call for total donor support in 2015 of $739 million, an increase of $405 million over 2000. These are a fraction of overall programme needs (commodities costs are only about a fifth of total service costs).

The global costs of gender violence and abuse are difficult to assess. They include the direct costs of, for example, treating the health effects of violence; ill health; missed work; law enforcement and protection; shelter; marital dissolution; child support; and all the other consequences of adapting to or escaping abuse. They also include the indirect costs of preventing women from working or contributing in other ways, and of missed education, including holding young girls out of school to avoid exposure to boys. In poor communities, the costs are reckoned largely in these missed development opportunities.

Elsewhere, the direct costs are equally important and often substantial. The World Bank estimates that in industrialized countries sexual assault and violence take away almost one in five healthy years of life of women aged 15-44.

30 **POLICY DIALOGUE ON POVERTY REDUCTION IN NICARAGUA** Nicaragua's per capita income in 2001 was $486, the second lowest in Latin America. Its foreign debt is twice its annual GNP. Pervasive poverty, exacerbated by rapid population growth, gender inequity, and wide income and educational disparities, inhibit the consolidation of democracy and sustained economic development.

Educated women in higher income groups have an average of two children; illiterate poor women tend to have six to eight. Adolescent fertility is the highest in the region: almost half of all Nicaraguan girls become pregnant by age 19. Fertility is particularly high among girls who are poor and out-of-school.

Recognizing that rapid population growth undermines its ability to provide quality education and basic social services, the Government has called for a rapid and urgent attention to population issues, involving civil society and donors.

Nicaragua's Strengthened Economic Growth and Poverty Reduction Strategy (SEGPRS) addresses Millennium Development Goals related to poverty reduction, primary education, water and sanitation, illiteracy, malnutrition, and maternal and child mortality.

As a result of UNFPA advocacy, the strategy calls for reproductive health information and services for adolescents in and out of school, and calls attention to violence against women. But it does not mention HIV/AIDS.

UNFPA's Nicaragua office offered technical assistance in developing tools to implement the strategy, including the Ministry of Health's 2002 National Sexual and Reproductive Health Programme and the Population Plan of Action.

SEGPRS analyses some population and development linkages, but does not yet address other key issues, such as migration flows, distribution of the population, rapid urban growth and sustainable use of space, and their links with environment and poverty.

However, the Government's new vision of development proposes wealth generation with the poor and for the poor; this assumes population factors are relevant to sustainable development efforts.

Investments in education bring substantial returns. Female education, apart from empowering the woman herself and widening her life choices, is particularly cost-effective because benefits pass on to her children.[39] However, the investment can be dissipated if lack of choice about the number, timing and spacing of children and rigid gender roles reduce women's social and economic participation.

Reproductive health adds another dimension to the improvement in "human capital". Reductions in maternal, infant and child mortality are development ends in themselves, and they have added effects on future economic production, fertility, informal old age support and other advantages.

The interaction of higher education, reduced fertility, women's economic and social participation, and greater investments in children's health and education amply justifies investments in both education and reproductive health in holistic development approaches.

The international goals for poverty reduction and improvement of life quality offer an ennobling vision. Achieving and protecting them will require both a focus on the goals themselves and sensitivity to the context. Universal access to reproductive health care, universal education, and women's empowerment are goals in their own right, but they are also conditions for ending poverty.

notes and indicators

Notes

CHAPTER 1

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20 Bilsborrow 1994; Boltvinik, J. 1994. "Poverty Measurement and Alternative Indicators of Development." Pp 57-83 in: van der Hoeven and Anker 1994, and Hatch and Frederick 1998

21 See also: Chung, et al. 1997

22 Ibid.

23 Hatch and Frederick 1998.

24 Zeller, M., et al. 2001. "An Operational Tool for Evaluating Poverty Outreach of Development Policies and Projects." Food Consumption and Nutrition Division. Discussion Paper. No. 111. Washington, D.C.: International Food Policy Research Institute.

25 UNDP 2000.

CHAPTER 3

1 Paes de Barros, R., et al. 2001. "Demographic Changes and Poverty in Brazil." Ch. 11 in: *Population Matters: Demographic Change, Economic Growth, and Poverty in the Developing World*, edited by N. Birdsall, A. C. Kelley, and S. W. Sinding. 2001. Oxford: Oxford University Press.

2 There are offsetting effects. A larger population contributes to a larger pool of creative resources. Pressure on natural resources and narrowing opportunities can encourage innovation such as new technologies to produce more food or conserve fuel. But investment is needed to exploit the "human resource". These arguments were developed by Julian Simon and others. See especially: Simon, J. 1981. *The Ultimate Resource.* Princeton, New Jersey: Princeton University Press.

3 The summary that follows is necessarily truncated. More extended discussions of the development of policy and science can be found in a large number of sources. Of particular value are: Bloom, D. E., D. Canning, and J. Sevilla. 2002. *Demographic Change and Economic Growth: The Importance of Age Structure.* Santa Monica, California: RAND Corporation; Seltzer, J. 2002. *The Origins and Evolution of Family Planning Programs in Developing Countries.* Santa Monica, California: RAND Corporation; Cassen, R. 1994. *Population and Development: Old Debates, New Conclusions.* New Brunswick, New Jersey, and Oxford: Transaction Publishers; and Lassonde, L. 1996. *Coping with Population Challenges.* London: Earthscan Publications.

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5 Demographers use these ages by convention. In contemporary society the start of employment and formal retirement are both later in life, but the change does not affect the argument.

6 External financial shocks and failure of regulatory frameworks led to the 1997-1998 economic catastrophe. Rapid recovery since then, although held back by continuing external problems, shows the value of the earlier demographic and social changes. The collapse hit the poor hardest and they continue to bear the brunt.

7 Some countries have reached fertility rates of 3 children or lower (e.g., Algeria, Turkey and Lebanon; Iran and Kazakhstan have reached replacement levels around 2.1) but most are higher (many above 4, including Libyan Arab Jamahiriya, Sudan, Jordan, Kuwait, Syria and the United Arab Emirates, and several above 5, including, in increasing order, Saudi Arabia, the Occupied Palestinian Territory, Yemen and Oman).

8 See, for example: Pearson, A. 22 May 2002. "Let's Talk about the Facts of Life." *London Evening Standard*, which asserts that "Britons are on the road to extinction" due to low fertility.

9 A discussion can be found in: UNFPA. 1998. *State of World Population 1998: The New Generations*, ch. 3. New York: UNFPA.

10 Sachs, J. D., and D. E. Bloom (eds.). 1997. *Emerging Asia: Changes and Challenges.* Manila: Asian Development Bank.

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12 These effects are elaborated in: Eastwood, R., and M. Lipton. 1999. "The Impact of Changes in Human Fertility on Poverty." *The Journal of Development Studies* 36(1): 1-30; and Eastwood, R., and M. Lipton. 2001. "Demographic Transition and Poverty: Effects via Economic Growth, Distribution and Conversion." Ch. 9 in: Birdsall, Kelley, and Sinding 2001.

13 Paes de Barros, et al. 2001.

14 The Millennium Development Goal of poverty reduction is expressed in terms of the incidence (the numbers of the poor), not the severity of poverty (or how poor they are). The effects of the redistribution of income (including those produced by demographic effects that lower wage rates) can markedly affect the incidence of poverty even when they do not alter its severity. If income flows from the near-poor to the rich, the incidence is unchanged but the intensity increases.

15 See: Eastwood and Lipton 1999, p. 13.

16 See citations in: Eastwood and Lipton 2001.

17 Descriptions of effects and citations can be found in: Eastwood and Lipton 2001.

18 This argument is most clearly developed in: Merrick, T. 2001. "Population and Poverty in Households: A Review of Reviews." Ch. 8 in: Birdsall, Kelley, and Sinding 2001.

CHAPTER 4

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4 Buvinic, M., and G. R. Gupta. 1997. "Female-Headed Households and Female-Maintained Families: Are They Worth Targeting to Reduce Poverty in Developing Countries?" *Economic Development and Cultural Change* 45(2): 259-280; and Quisumbing, A. R., L. Haddad, and C. Peña. 2001. "Are Women Overrepresented Among the Poor? An Analysis of Poverty in Ten Developing Countries." *Journal of Development Economics* 66(1): 225-269.

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6 See: UNIFEM. 2000. *Progress of the World's Women 2000: UNIFEM Biennial Report.* New York: UNIFEM.

7 Building on work by: Kishor, S. (1999. "Women's Empowerment and Contraceptive Use in Egypt." Paper presented at the Annual Meeting of the Population Association of America, 24-27 March 1999, New York, New York; and 2000. "Empowerment of Women in Egypt and Links to the Survival and Health of their Infants." Ch. 6 in: *Women's Empowerment and Demographic Processes: Moving Beyond Cairo*, edited by H. B. Presser and G. Sen. 2000. Oxford: Oxford University Press.) and Smith, L. C., et al. (2001. "The Importance of Women's Status for Child Nutrition in Developing Countries." Draft research report. Washington, D.C.: International Food Policy Research Institute.) using Demographic and Health Survey data.

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9 Kishor, S. 1996. *Status of Women: Indicators for Twenty Five Countries.* DHS Comparative Study Series. No. 21. Calverton, Maryland: Macro International.

10 Floro 2001.

11 UNDP. 1999. *Human Development Report 1999: Globalization with a Human Face*, Table 27. New York. Oxford University Press.

12 Floro, M. S. 1995. "Women's Well-Being, Poverty, and Work Intensity." *Feminist Economics* 1(3): 1-25.

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15 Women's Environment and Development Organization. 1999. *A Gender Agenda for the World Trade Organization: A WEDO Primer.* November 1999. New York: Women's Environment and Development Organization.

16 The World Bank. 2001a.

17 On the other hand, if young women take paid work to help finance the cost of marriage, parents may see this as helping the husband's family more than their own, further undercutting their motivation. This may be offset by daughters' ability to support their parents in old age.

18 Floro 2001.

19 Ibid.

20 Klasen, S. 1999. "Does Gender Inequality Reduce Growth and Development? Evidence from Cross-Country Regressions." Working Paper. No. 7. For: The World Bank 2001a. (Background paper available at: http://www.worldbank.org/gender/prr/wp7.pdf.)

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22 The World Bank. 2001b. *World Development Report 2000/2001: Attacking Poverty.* Washington, D.C.: The World Bank and Oxford University Press.

23 When the underlying determinants of food security are considered against data on child underweight rates from 63 developing countries from 1970-1995, representing 88 per cent of the developing world's population (Smith, L C., and L. Haddad. 2000. *Explaining Child Malnutrition in Developing Countries: A Cross Country Analysis.* IFPRI Research Report. No. 111. Washington, D.C.: International Food Policy Research Institute.).

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29 Joint United Nations Programme on HIV/AIDS (UNAIDS). 2002. *Report on the Global HIV/AIDS Epidemic: July 2002.* Geneva: UNAIDS.

30 United Nations General Assembly Special Session on AIDS, June 2001; and Mocumbi, Pascoal. 2001. "A Time for Frankness on AIDS and Africa." *The New York Times.* Web site: http://www.nytimes.com/2001/06//20/opinion20MOCU.html.

31 Plus News. 3 December 2001. Africa: Interview with Stephen Lewis, UN Special Envoy. Parts 1 and 2. New York: United Nations Office for the Coordination of Humanitarian Affairs.

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33 Thompson, D. 2002. *Coordinates 2002: Charting Progress against AIDS, Tuberculosis and Malaria,* p. 14. Geneva: WHO.

34 UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000,* p. 11. Geneva: UNAIDS.

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CHAPTER 5

1 In 1990, communicable diseases caused 59 per cent of deaths and 64 per cent of DALY (disability-adjusted life year) loss among the 20 per cent of the world's population that live in countries with the lowest per capita incomes, compared to 34 per cent of deaths and 44 per cent of DALY loss among the world's population as a whole. Communicable diseases also contribute disproportionately to mortality gap and the DALY gap than do non-communicable diseases. See: Gwatkin, D. R., and M. Guillot. 2000. *The Burden of Disease among the Global Poor.* Washington, D.C.: The World Bank.

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7 As AbouZahr and Vaughan (2000) note, these estimates of disease burdens were made in 1993, prior to full appreciation of the impacts of HIV/AIDS. For this and for technical reasons (related to the DALY measure, see the citation and the concluding chapter of this report), these are most likely very conservative estimates.

8 Loewenson, R., and A. Whiteside. 2001. *HIV/AIDS: Implications for Poverty Reduction.* United Nations Development Programme Policy Paper. New York: UNDP.

9 WHO and the World Bank 2002.

10 Ibid., p. 16.

11 This applies not only to the sexual contact of the individual, but also to worries generated when the partner has other sexual contacts.

12 Jensen, E. R., and D. A. Ahlburg. 1999. "A Multicountry Analysis of the Impact of Unwantedness and Number of Children on Child Health and Preventive Curative Care." Washington, D.C.: POLICY Project, the Futures Group International. Accessible on the web site: www.tfgi.com.

13 "Domestic violence against women is frequent in all countries covered by the study, and is mentioned in 90 per cent of the communities. Since this subject is so often taboo, it is notable that it was discussed at all. In groups in Ethiopia and the Kyrgyz Republic it was impossible to mention the subject, and in Bangladesh discussions were held in hushed voices." WHO and the World Bank 2002, p. 17.

14 Ibid., p. 15.

15 Jensen and Ahlburg 1999.

16 The differentials presented here and following sections are based on the reports in the series, *Socio-economic Differences in Health, Nutrition and Population in [Country],* prepared by Davidson R. Gwatkin, Shea Rutstein, Kiersten Johnson, Rohini P. Pande and Adam Wagstaff for the Health, Nutrition and Poverty (HNP)/Poverty Thematic Group of the World Bank. Forty-four countries with a Demographic and Health Survey were analysed. Within regions, the countries included were: East Asia and the Pacific—the Philippines, Viet Nam and Indonesia; Europe and Central Asia—Turkey, Kazakhstan, Kyrgyz Republic and Uzbekistan; Latin America and the Caribbean—Peru, Bolivia, Brazil, Guatemala, Nicaragua, Haiti, Colombia, Paraguay and the Dominican Republic; Middle East and North Africa—Egypt, Morocco and Turkey; South Asia—India, Bangladesh, Nepal and Pakistan; and sub-Saharan Africa—Mali, United Republic of Tanzania, Cameroon, Ghana, Cote d'Ivoire, Togo, Zambia, Zimbabwe, Malawi, Uganda, Chad, Niger, Mozambique, Central African Republic, Madagascar, Benin, Kenya, Senegal, Namibia, Nigeria, Comoros and Burkina Faso. The sampled countries have overall fertility levels higher than the 3.6 of the less-developed regions (excluding China) but lower than the 5.5 of the least developed countries. The surveys are more concentrated in lower and middle income countries where the primary donor for the surveys (the United States Agency for International Develop-ment) concentrates its efforts. There is a bias towards larger countries and those in need of programme assistance.

17 Child mortality in Panama from the United Nations Population Division (special tabulation). For U.S. data see: Guest, A. M., G. Almgren, and J. M. Hussey. 1998. "The Ecology of Race and Socio-economic Distress: Infant and Working-age Mortality in Chicago." *Demography* 35(1): 23-34 See also: McCord, C., and H. P. Freeman 1990. "Excess Mortality in Harlem." *The New England Journal of Medicine* 322(3): 173-177

18 Wagstaff, A. 2000. "Socioeconomic Inequalities in Child Mortality: Comparisons Across Nine Developing Countries." *Bulletin of the World Health Organization* 78(1): 19-29

19 Jensen and Ahlburg 1999.

20 Shen, C., et al. 1999. "Maternal Mortality Women's Status, and Economic Dependency in Less-Developed Countries: A Cross-National Analysis." *Social Science and Medicine* 49(2): 197-214.

21 Hill, K., C. AbouZahr, and T. Wardlaw. 2001 "Estimates of Maternal Mortality for 1995." *Bulletin of the World Health Organization* 79(3): 182-193.

22 Strong, M. 1992. "The Health of Adults in the Developing World: The View from Bangladesh." *Health Transition Review* 2(2): 215-224.

23 UNFPA. 2000. *The State of World Population 2000: Lives Together, World's Apart: Men and Women in a Time of Change,* p. 11. New York: UNFPA.

24 This is true of morbidity measures in general. The absence of effective registration systems and paucity of wealth or income measures even renders mortality comparisons within countries a difficult enterprise. (For discussion, see: Wagstaff 2000.)

25 Quality of care initiatives are an important component of most programmes of assistance to reproductive health care providers. But high or irregular workloads, poor compensation, staff turnover and underdeveloped systems of monitoring and supervision pose constant challenges to attaining and maintaining standards.

26 Gwatkin D., and G. Deveshwar-Bahl. 2002. "Socio-Economic Inequalities in Use of Safe Motherhood Services in Developing Countries." A presentation given in London, 6 February 2002.

27 See analyses of African countries in the series: Gwatkin, D. R., et al. 2000. *Socio-economic Differences in Health, Nutrition and Population in [Country].* Washington, D.C.: the Health, Nutrition and Poverty (HNP)/Poverty Thematic Group, the World Bank.

28 Gwatkin, D. R., et al. 2000.

29 In principle, it should be possible to use the indicators that characterize intra-national wealth differences to construct a scale applicable across all countries. Since programmes to address underserved populations are formulated within countries, such an effort would mostly serve academic needs without assisting practical strategies.

30 For comparative studies of the efficiency of service delivery systems, analyses need to statistically correct for rural-urban proportions. Comparing access within countries looks at differentials within urban and rural places

31 Gwatkin, D. R., et al. 2000. *Socio-economic Differences in Health, Nutrition and Population in India.* Washington, D.C.: the Health, Nutrition and Poverty (HNP)/Poverty Thematic Group, the World Bank.

32 United Nations. 2002. *World Urbanization Prospects 2001* (ESA/P/WP.173). New York: Population Division, Department of Economic and Social Affairs, United Nations; and Naylor, R. L., and W. P. Falcon. 1996. "Is the Locus of Poverty Changing." *Food Policy* 21(2): 1.

33 Hewett, P. C., and M. R. Montgomery. 2001. *Poverty and Public Services in Developing Country Cities.* Population Council Policy Research Division Working Paper. No. 154. New York: The Population Council.

34 United Nations 2002.

35 Commission on Macro-economics and Health, World Health Organization (WHO). 2001. *Macro-economics and Health: Investing in Health for Economic Development.* Geneva: WHO.

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40 Chandani, Y., et al. 2000. *Ghana: Implications of Health Sector Reform for Family Planning Logistics.* Arlington, Virginia: Family Planning Logistics Management Project, John Snow Inc. for United States Agency for International Development (USAID).

41 Bates, J., et al. 2000. *Implications of Health Sector Reform for Contraceptive Logistics: A Preliminary Assessment for Sub-Saharan Africa.* Arlington, Virginia: Family Planning Logistics Management Project, John Snow Inc. for USAID

42 Newbrander, W., C. J. Cuellar, and B. Timmons. 2000. "The PROSALUD Model for Expanding Access to Health Services." Unpublished paper. Boston, Massachusetts: Management Sciences for Health.

43 Langer, Nigena, and Catino 2000.

44 UNAIDS. 2000. *HIV and Health-care Reform in Phayao: From Crisis to Opportunity,* p.9. Joint United Nations Programme on HIV/AIDS Case Study. UNAIDS Best Practices Collection. Geneva: UNAIDS.

45 The World Bank 2001.

46 Filmer, D., and L. Pritchett. 1999. "The Impact of Public Spending on Health: Does Money Matter?" *Social Science and Medicine* 49(10): 1309-1327. Cited in: The World Bank 2001, p. 81.

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48 Mahal, A. 2000. "Do the Poor or the Rich Benefit More from Government Health Services: The Case of India." Health/Nutrition/Population and Poverty Seminar Report, 11 July 2000. Washington, D.C.: The World Bank.

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50 Begum, S. 1997. *Health and Poverty in the Context of Country Development Strategy: A Case Study on Bangladesh.* Macroeconomics Health and Development Series. No. 26. Geneva: WHO. Cited in: "Bangladesh: An Intervention Study of Factors Underlying Increasing Equity in Child Survival," by A. Bhuiya, et al. 2000. Ch. 16 in: *Challenging Inequities in Health from Ethics to Action,* edited by T. Evans, et al. 2000. London: Oxford University Press.

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55 Hsiao, W. C., and Y. Liu. 2001. "Health Care Financing: Assessing Its Relationship to Health Equity." Ch. 18 in: Evans, et al. 2000.

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65 Isaacs, Stephen, and G. Solimano. (No date.). "Health Reform and Civil Society in Latin America." L'Encyclopédie de L'Agora. Web site: http://agora.qc.ca. Accessed on 13 March 2002.

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CHAPTER 6

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3 UNAIDS 2002.

4 Ibid.

5 Thompson 2002.

6 Loewenson, R., and A. Whiteside. 2001. *HIV/AIDS: Implications for Poverty Reduction,* p. 23. United Nations Development Programme Policy Paper. New York: UNDP.

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10 Ibid., p. 125.

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	Indicators of Mortality			Indicators of Education				Reproductive Health Indicators			
	Infant mortality Total per 1,000 live births	Life expectancy M/F	Maternal mortality ratio	Primary enrolment (gross) M/F	Proportion completing final grade, M/F	Secondary enrolment (gross) M/F	% Illiterate (>15 years) M/F	Births per 1,000 women aged 15-19	Contraceptive Prevalence Any method	Contraceptive Prevalence Modern methods	HIV prevalence rate (%) (15-24) M/F
World Total	55	63.9 / 68.1	400					50	61	54	0.82 / 1.39
More developed regions (*)	8	71.9 / 79.3	21					27	69	56	
Less developed regions (+)	59	62.5 / 65.7	440					54	59	54	
Least developed countries (‡)	92	50.6 / 52.2	1,000					127			
AFRICA (1)	**83**	**50.5 / 52.1**	**1,000**					**108**	**25**	**20**	
EASTERN AFRICA	**94**	**44.8 / 46.0**	**1,300**					**112**	**21**	**16**	
Burundi	111	39.8 / 41.4	1,900	56 / 46	45 / 41	8 / 6	42 / 56	60	9	1	4.96 / 11.05
Eritrea	82	51.1 / 53.7	1,100	58 / 48	43 / 28	28 / 19		112	5	4	2.78 / 4.30
Ethiopia	106	42.8 / 43.8	1,800	79 / 48	31 / 18	21 / 13	51 / 66	78	8	6	4.40 / 7.82
Kenya	59	48.7 / 49.9	1,300	92 / 92	58 / 57	32 / 29	10 / 21	90	39	32	6.01 / 15.56
Madagascar	91	52.5 / 54.8	580	94 / 92	26 / 27	16 / 16		136	19	12	0.07 / 0.24
Malawi	130	39.6 / 39.0	580		61 / 40		24 / 51	152	31	26	6.35 / 14.89
Mauritius (2)	16	68.4 / 75.8	45	108 / 108		70 / 71	12 / 18	34	75	49	
Mozambique	128	37.3 / 38.6	980	83 / 60	43 / 29	11 / 7	38 / 69	129	6	5	6.13 / 14.67
Rwanda	119	40.2 / 41.7	2,300	115 / 114		10 / 9	25 / 37	60	13	4	4.92 / 11.20
Somalia	113	47.4 / 50.5	1,600					213			
Uganda	94	45.3 / 46.8	1,100	162 / 146	74 / 49	20 / 13	21 / 41	211	23	18	1.99 / 4.63
United Republic of Tanzania	73	50.1 / 52.0	1,100	65 / 65	58 / 60		15 / 31	92	25	17	3.55 / 8.06
Zambia	80	42.6 / 41.7	870	89 / 84		30 / 23	14 / 26	146	25	14	8.07 / 20.98
Zimbabwe	55	43.3 / 42.4	610		116 / 111		6 / 14	105	54	50	12.38 / 33.01
Middle Africa (3)	87	48.8 / 51.1	1,000					204	10	3	
Angola	118	44.5 / 47.1	1,300	99 / 83		19 / 13		229	8	4	2.23 / 5.74
Cameroon	79	49.3 / 50.6	720	99 / 82		23 / 18	16 / 28	127	19	7	5.44 / 12.67
Central African Republic	93	42.7 / 46.0	1,200	69 / 46			38 / 62	141	15	3	5.83 / 13.54
Chad	116	45.1 / 47.5	1,500	85 / 49	26 / 10	17 / 4		195	8	2	2.38 / 4.28
Congo, Democratic Republic of (4)	77	51.0 / 53.3	940	48 / 44		24 / 13	6 / 19	230	8	2	2.93 / 5.91
Congo, Republic of	66	49.6 / 53.7	1,100	59 / 56	45 / 43		11 / 23	146			3.28 / 7.80
Gabon	80	51.8 / 54.0	620	155 / 153	79 / 80	59 / 51		161	33	12	
NORTHERN AFRICA (5)	**49**	**64.8 / 68.0**	**450**						**47**	**42**	
Algeria	43	68.7 / 71.8	150	114 / 104	93 / 88	66 / 67	22 / 40	20	64	50	
Egypt	40	66.7 / 69.9	170	104 / 96	104 / 92	84 / 78	32 / 54	34	56	54	
Libyan Arab Jamahiriya	25	69.2 / 73.3	120	154 / 152		73 / 81	8 / 29	35	40	26	
Morocco	42	66.8 / 70.5	390	107 / 87	63 / 47	44 / 35	37 / 62	28	50	42	
Sudan	78	55.6 / 58.4	1,500	60 / 51	38 / 33	30 / 28	29 / 51	57	8	7	1.08 / 3.14
Tunisia	26	69.6 / 72.2	70	123 / 116	93 / 90	72 / 73	17 / 37	17	60	51	
SOUTHERN AFRICA	**63**	**45.6 / 47.1**	**360**						**52**	**51**	
Botswana	67	36.5 / 35.6	480	106 / 105	96 / 107	73 / 80	24 / 18	63	40	39	16.08 / 37.49
Lesotho	111	40.9 / 39.6	530	97 / 106	55 / 83	26 / 37	26 / 6	67	30	30	17.40 / 38.08
Namibia	65	44.3 / 44.1	370	125 / 127	86 / 94	55 / 64	16 / 17	81	29	26	11.10 / 24.29
South Africa	59	46.5 / 48.3	340	129 / 125	95 / 100	98 / 109	13 / 15	73	56	55	10.66 / 25.64
WESTERN AFRICA (6)	**87**	**50.7 / 51.8**	**1,100**					**123**	**14**	**8**	
Benin	81	52.5 / 55.7	880	102 / 66	52 / 25	30 / 13	45 / 74	113	16	3	1.18 / 3.72
Burkina Faso	87	47.0 / 49.0	1,400	50 / 34	29 / 20	12 / 7	64 / 84	151	12	5	3.98 / 9.73
Côte d'Ivoire	81	47.7 / 48.1	1,200	89 / 66	50 / 31	30 / 16	43 / 58	121	15	7	2.92 / 8.31
Gambia	115	45.7 / 48.5	1,100	88 / 75	80 / 60	38 / 25	54 / 68	139	10	9	0.53 / 1.35
Ghana	62	56.0 / 58.5	590				18 / 34	78	22	13	1.36 / 2.97
Guinea	114	48.0 / 49.0	1,200	72 / 45	49 / 19	21 / 8		168	6	4	
Guinea-Bissau	121	44.0 / 46.9	910				43 / 74	195	8	4	1.06 / 2.98
Liberia	79	54.6 / 56.7	1,000	95 / 70		30 / 19	28 / 60	230	6	6	
Mali	120	51.1 / 53.0	630	63 / 44	33 / 14	19 / 10	48 / 62	195	8	6	1.37 / 2.08
Mauritania	97	50.9 / 54.1	870	86 / 81	52 / 39	21 / 15	49 / 69	147	8	5	
Niger	126	45.9 / 46.5	920	38 / 24	25 / 15	9 / 5	75 / 91	233	14	4	
Nigeria	79	52.0 / 52.2	1,100		75 / 59		25 / 41	104	15	9	2.99 / 5.83
Senegal	57	52.5 / 56.2	1,200	76 / 63	48 / 34	24 / 15	51 / 70	100	13	8	0.19 / 0.54
Sierra Leone	146	39.2 / 41.8	2,100					212	4	4	2.49 / 7.54
Togo	75	51.1 / 53.3	980	141 / 107	86 / 41	47 / 19	26 / 55	93	24	7	2.05 / 5.94
ASIA	**53**	**65.8 / 69.2**	**280**						**64**	**59**	
EASTERN ASIA (8)	**34**	**69.9 / 74.9**	**55**						**82**	**81**	
China	37	69.1 / 73.5	60	106 / 109	111 / 106	65 / 58	8 / 22	5	84	83	0.16 / 0.09
Democratic People's Republic of Korea	39	62.5 / 68.0	35					2	62	53	
Hong Kong SAR, China (9)	4	77.3 / 82.8						7	86	80	
Japan	3	77.8 / 85.0	12 [10]	102 / 102		101 / 103		4	59	53	0.03 / 0.04

Monitoring ICPD Goals – Selected Indicators

	Indicators of Mortality			Indicators of Education				Reproductive Health Indicators			
	Infant mortality Total per 1,000 live births	Life expectancy M/F	Maternal mortality ratio	Primary enrolment (gross) M/F	Proportion completing final grade, M/F	Secondary enrolment (gross) M/F	% Illiterate (>15 years) M/F	Births per 1,000 women [illegible] 15–19	Contraceptive Prevalence Any method	Modern methods	HIV prevalence rate (%) (15–24) M/F
Mongolia	58	61.9 / 65.9	65	92 / 96	77 / 88		1 / 1	53	60	46	
Republic of Korea	7	71.8 / 79.1	20		95 / 98		1 / 3	3	81	67	0.03 / 0.01
SOUTH-EASTERN ASIA	**41**	**64.8 / 69.2**	**300**						**58**	**49**	
Cambodia	73	53.6 / 58.6	590	128 / 110	68 / 51	29 / 15	20 / 40	97	24	19	0.97 / 2.49
Indonesia	40	65.3 / 69.3	470		90 / 92		7 / 17	53	57	55	0.07 / 0.06
Lao People's Democratic Republic	88	53.3 / 55.8	650	120 / 102	70 / 59	39 / 27		91	32	29	0.05 / 0.03
Malaysia	10	70.6 / 75.5	39	99 / 99	89 / 90	93 / 103	8 / 15	18	55	30	0.70 / 0.12
Myanmar	87	53.8 / 58.8	170	115 / 114		36 / 36	11 / 19	29	33	28	
Philippines	29	68.0 / 72.0	240				4 / 4	33	47	28	0.02 / 0.02
Singapore	5	75.9 / 80.3	9			128 /	3 / 11	7	74	73	0.15 / 0.16
Thailand	21	67.9 / 73.8	44	95 / 92		87 / 89	3 / 6	51	72	70	1.11 / 1.66
Viet Nam	34	66.9 / 71.6	95	113 / 107		64 / 58	4 / 8	20	75	56	0.32 / 0.17
SOUTH CENTRAL ASIA	**69**	**62.7 / 64.1**	**410**						**48**	**41**	
Afghanistan	161	43.0 / 43.5	820		15 / 0		46 / 75	111	5	4	
Bangladesh	67	60.6 / 60.8	600	125 / 120	68 / 72	45 / 50	47 / 69	125	54	43	0.01 / 0.01
Bhutan	54	62.0 / 64.5	500	23 / 19		11 / 9		57	19	19	
India	65	63.6 / 64.9	440	107 / 93	88 / 63	59 / 39	32 / 59	44	48	43	0.34 / 0.71
Iran (Islamic Republic of)	36	68.8 / 70.8	130		95 / 89		15 / 28	28	73	56	0.05 / 0.01
Nepal	71	60.1 / 59.6	830	128 / 100	70 / 42	56 / 38	38 / 74	124	39	35	0.27 / 0.28
Pakistan	87	61.2 / 60.9	200	109 / 62		45 / 29	41 / 70	50	28	20	0.06 / 0.05
SriLanka	20	69.9 / 75.9	60	112 / 110	98 / 102	68 / 74	5 / 10	23	66	44	0.03 / 0.04
WESTERN ASIA	**39**	**68.0 / 72.1**	**230**						**47**	**28**	
Iraq	64	63.5 / 66.5	370	96 / 80	59 / 51	25 / 14	44 / 76	41	14	10	
Israel	6	77.1 / 81.0	8	108 / 107		89 / 88	3 / 7	17	68	52	
Jordan	23	69.7 / 72.5	41	68 / 69		65 / 67	4 / 15	38	53	38	
Kuwait	11	74.9 / 79.0	25	79 / 77	69 / 71	63 / 64	15 / 19	28	50	41	
Lebanon	17	71.9 / 75.1	130	113 / 108		85 / 94	7 / 18	25	61	37	
Occupied Palestinian Territory	21	70.8 / 74.0						94			
Oman	23	70.2 / 73.2	120	77 / 72	76 / 76	68 / 67	18 / 35	89	24	18	
Saudi Arabia	21	71.1 / 73.7	23	73 / 70	68 / 69	70 / 62	16 / 31	48	32	29	
Syrian Arab Republic	22	70.6 / 73.1	200	109 / 99	95 / 86	44 / 39	11 / 37	38	36	28	
Turkey (11)	39	68.0 / 73.2	55		95 / 89	81 / 57	6 / 22	51	64	38	
United Arab Emirates	11	74.1 / 78.4	30	96 / 92	76 / 86	75 / 80	24 / 19	64	28	24	
Yemen	62	60.7 / 62.9	850	100 / 55		66 / 24	31 / 72	125	21	10	
EUROPE	**9**	**69.6 / 77.9**	**28**					**21**	**67**	**49**	
EASTERN EUROPE	**15**	**63.1 / 73.8**	**50**						**61**	**35**	
Bulgaria	15	67.1 / 74.8	23	102 / 99	92 / 92	88 / 86	1 / 2	41	42	25	
Czech Republic	5	72.1 / 78.7	14	104 / 103	110 / 107	81 / 84		17	72	63	0.00 / 0.00
Hungary	9	67.8 / 76.1	23	103 / 102		97 / 99	0 / 1	21	77	68	0.10 / 0.02
Poland	9	69.8 / 78.0	12				0 / 0	16	49	19	0.09 / 0.05
Romania	22	66.5 / 73.3	60	104 / 102		80 / 81	1 / 2	37	64	30	
Slovakia	8	69.8 / 77.6	14	102 / 100	96 / 97	85 / 86		24	74	41	0.00 / 0.00
NORTHERN EUROPE (12)	**5**	**74.9 / 80.5**	**12**					**20**	**78**	**75**	
Denmark	5	74.2 / 79.1	15	103 / 103		123 / 130		7	78	72	0.14 / 0.07
Estonia	10	65.8 / 76.4	80	103 / 99	89 / 86	103 / 106		27	70	56	2.49 / 0.62
Finland	4	74.4 / 81.5	6	99 / 99		116 / 126		7	77	75	0.04 / 0.03
Ireland	6	74.4 / 79.6	9	142 / 141		106 / 113		16			0.06 / 0.05
Latvia	14	65.7 / 76.2	70	106 / 99		87 / 86	0 / 0	21	48	39	0.94 / 0.24
Lithuania	9	67.6 / 77.7	27	102 / 99	97 / 94	90 / 90	0 / 0	27	47	31	0.16 / 0.05
Norway	5	76.0 / 81.9	9	102 / 102		119 / 122		10	74	69	0.08 / 0.04
Sweden	3	77.6 / 82.6	8	109 / 112		142 / 181		[illegible]	[illegible]	[illegible]	[illegible]
United Kingdom	5	75.7 / 80.7	10	101 / 102		145 / 167		24	82	82	0.10 / 0.05
SOUTHERN EUROPE (13)	**7**	**74.4 / 80.8**	**12**					**11**	**68**	**48**	
Albania	25	70.9 / 76.7	31		84 / 95			16	58	15	
Bosnia & Herzegovina	14	71.3 / 76.7	15					23	48	16	
Croatia	8	70.3 / 78.1	18	98 / 97	80 / 79	85 / 87	[illegible]	19			0.00 0.00
Greece	6	75.9 / 81.2	2	97 / 97		95 / 96	[illegible]	10			0.14 0.07
Italy	5	75.5 / 81.9	11	103 / 102		96 / 95	[illegible]	6	60	39	0.29 0.26
Macedonia (Former Yugoslav Republic of)	16	71.4 / 75.8	17	104 / 102	94 / 87	84 / 81		26			0.00 0.00
Portugal	7	72.6 / 79.6	12	126 / 121		108 / 117	[illegible]	17	66	33	0.41 0.19
Slovenia	5	72.3 / 79.6	17	98 / 97	90 / 94	97 / 100	[illegible]	8	74	59	0.00 0.00
Spain	4	75.4 / 82.3	5	108 / 107		110 / 117	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Yugoslavia	18	70.9 / 75.6	16	69 / 70		61 / 64		25	58	33	

	Indicators of Mortality			Indicators of Education				Reproductive Health Indicators			
	Infant mortality Total per 1,000 live births	Life expectancy M/F	Maternal mortality ratio	Primary enrolment (gross) M/F	Proportion completing final grade, M/F	Secondary enrolment (gross) M/F	% Illiterate (>15 years) M/F	Births per 1,000 women aged 15-19	Contraceptive Prevalence Any method	Contraceptive Prevalence Modern methods	HIV prevalence rate (%) (15-24) M/F
WESTERN EUROPE (14)	**5**	**75.2 / 81.7**	**14**					**9**	**74**	**71**	
Austria	5	75.4 / 81.5	11	100 / 101		97 / 94		12	51	47	0.23 / 0.12
Belgium	4	75.7 / 81.9	8					8	78	74	0.12 / 0.12
France	5	75.2 / 82.8	20	105 / 104		111 / 111		9	75	69	0.26 / 0.18
Germany	5	75.0 / 81.1	12	106 / 105		128 / 66		11	75	72	0.10 / 0.05
Netherlands	5	75.6 / 81.0	10	109 / 107		128 / 122		4	79	76	0.20 / 0.09
Switzerland	5	75.9 / 82.3	8	102 / 101		98 / 90		5	82	78	0.46 / 0.40
LATIN AMERICA & CARIBBEAN	**32**	**67.2 / 73.6**	**190**					**71**	**69**	**60**	
CARIBBEAN (15)	**35**	**65.4 / 70.9**	**400**					**68**	**59**	**56**	
Cuba	7	74.8 / 78.7	24	100 / 99		77 / 82	3 / 3	65	70	67	0.09 / 0.05
Dominican Republic	36	64.4 / 70.1	110	136 / 130	78 / 86	61 / 72	16 / 16	93	64	59	2.10 / 2.76
Haiti	61	50.2 / 56.5	1,100	150 / 153			46 / 50	64	27	21	4.06 / 4.96
Jamaica	20	73.7 / 77.8	120	97 / 98	85 / 93	88 / 92	16 / 9	46	66	63	0.82 / 0.86
Puerto Rico	10	71.2 / 80.1	30				6 / 6	63	78	68	
Trinidad & Tobago	13	72.5 / 77.2	65	102 / 101	79 / 84	77 / 84		34	53	44	2.42 / 3.23
CENTRAL AMERICA	**30**	**69.1 / 74.7**	**110**						**63**	**55**	
Costa Rica	11	75.0 / 79.7	35		91 / 87		4 / 4	81	75	65	0.59 / 0.27
El Salvador	26	67.7 / 73.7	180	113 / 109	77 / 75	50 / 50	18 / 23	87	60	54	0.77 / 0.36
Guatemala	41	63.0 / 68.9	270	108 / 96	63 / 50	36 / 31	23 / 37	111	38	31	0.91 / 0.85
Honduras	33	63.2 / 69.1	220		64 / 71		24 / 24	103	50	41	1.20 / 1.50
Mexico	28	70.4 / 76.4	65	114 / 113	87 / 86	70 / 72	6 / 10	64	67	58	0.37 / 0.10
Nicaragua	36	67.2 / 71.9	250		61 / 70		33 / 33	138	60	57	0.23 / 0.08
Panama	19	72.6 / 77.3	100				7 / 8	75	58	54	1.88 / 1.25
SOUTH AMERICA (16)	**33**	**66.7 / 73.6**	**200**					**70**	**73**	**63**	
Argentina	20	70.6 / 77.7	85	120 / 120	97 / 98	86 / 93	3 / 3	61			0.86 / 0.34
Bolivia	56	61.9 / 65.3	550		80 / 75		7 / 19	75	53	27	0.11 / 0.06
Brazil	38	64.7 / 72.6	260	156 / 152		76 / 89	14 / 14	71	77	70	0.64 / 0.48
Chile	12	73.0 / 79.0	33	108 / 104	92 / 92	85 / 86	4 / 4	44			0.36 / 0.13
Colombia	26	69.2 / 75.3	120	112 / 112	84 / 87	50 / 56	8 / 8	80	77	64	0.85 / 0.19
Ecuador	41	68.3 / 73.5	210	113 / 113	96 / 96	56 / 57	6 / 9	66	66	50	0.31 / 0.15
Paraguay	37	68.6 / 73.1	170	117 / 114	85 / 87	49 / 52	5 / 7	75	57	48	
Peru	37	67.3 / 72.4	240	127 / 125	90 / 89	83 / 78	5 / 14	53	69	50	0.42 / 0.18
Uruguay	13	71.6 / 78.9	50	113 / 112	95 / 101	76 / 101	2 / 2	70			0.53 / 0.20
Venezuela	19	70.9 / 76.7	43		77 / 79		6 / 7	95	49	38	
NORTHERN AMERICA (17)	**7**	**74.7 / 80.5**	**11**					**46**	**76**	**71**	
Canada	5	76.2 / 81.8	6	97 / 97		106 / 104		19	75	73	0.28 / 0.18
United States of America	7	74.6 / 80.4	12	101 / 104		112 / 81		49	76	71	0.48 / 0.23
OCEANIA	**24**	**72.0 / 76.9**	**260** [7]					**39**	**62**	**58**	
AUSTRALIA-NEWZEALAND	**5**	**76.2 / 81.8**	**8** [10]						**76**	**72**	**0.02 / 0.01**
Australia (18)	5	76.4 / 82.0	6 [10]					18	76	72	0.12 / 0.02
Melanesia (19)	52	59.5 / 61.9	310								
New Zealand	6	75.3 / 80.7	15 [10]					31	75	72	0.05 / 0.02
Papua New Guinea	62	56.8 / 58.7	390	91 / 78	64 / 53	26 / 18		84	26	20	0.33 / 0.39
COUNTRIES WITH ECONOMIES IN TRANSITION OF THE FORMER USSR (20)											
Armenia	15	70.3 / 76.2	29					32	61	22	0.23 / 0.06
Azerbaijan	29	68.7 / 75.5	37	103 / 103	103 / 100	84 / 84		26	55	16	0.06 / 0.02
Belarus	12	62.8 / 74.4	33	113 / 108	95 / 92	85 / 88	0 / 1	29	50	42	0.59 / 0.20
Georgia	18	69.5 / 77.6	22	95 / 95		79 / 78		33	41	20	0.08 / 0.02
Kazakhstan	42	59.6 / 70.7	80	97 / 97	99 / 101	87 / 87		45	66	53	0.13 / 0.03
Kyrgyzstan	37	64.8 / 72.3	80	105 / 103		85 / 88		29	60	49	0.00 / 0.00
Republic of Moldova	20	62.8 / 70.3	65		82 / 81		0 / 1	43	62	43	0.46 / 0.14
Russian Federation	17	60.0 / 72.5	75	80 / 79	91 / 90	101 / 70	0 / 1	32			1.87 / 0.67
Tajikistan	53	65.2 / 70.8	120				0 / 1	24	34	27	0.00 / 0.00
Turkmenistan	49	63.9 / 70.4	65					18	62	53	0.00 / 0.00
Ukraine	15	62.7 / 73.5	45	84 / 83	55 / 55	87 / 100		39	68	38	1.96 / 0.88
Uzbekistan	37	66.8 / 72.5	60					51	67	63	0.00 / 0.00

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Demographic, Social and Economic Indicators

	Total population (millions) (2002)	Projected population (millions) (2050)	Ave. pop. growth rate (%) (2000-2005)	% urban (2001)	Urban growth rate (2000-2005)	Pop./ ha arable & perm. crop land	Total fertility rate (2000-2005)	% births with skilled attendants	GNI per capita PPP$ (2000)	Expndtrs/ primary student (% of GDP per capita)	Health expenditures public (% of GDP)	External population assistance (US$,000)	Under 5 mortality M/F	Per capita energy consumption	Access to safe water
World Total	6,211.1	9,322.3	1.2	48	2.1		2.68	77				(1,655,138)	79 / 79		
More developed regions (*)	1,196.0	1,181.1	0.2	76	0.4		1.50	99					10 / 9		
Less developed regions (+)	5,015.1	8,141.1	1.5	41	2.8		2.92	58					86 / 86		
Least developed countries (‡)	692.2	1,829.5	2.5	26	4.6		5.24	34					154 / 147		
AFRICA (1)	**831.9**	**2,000.4**	**2.3**	**38**	**3.8**		**4.97**	**47**				**431,968** [21]	**143 / 134**		
EASTERN AFRICA	**263.0**	**691.1**	**2.4**	**25**	**4.7**		**5.83**	**34**					**168 / 155**		
Burundi	6.7	20.2	3.0	9	6.4	5.1	6.80	25	580		0.6	740	207 / 188		
Eritrea	4.0	10.0	4.2	19	6.3	5.5	5.28	21	960	11.1	2.9	3,518	149 / 134		46
Ethiopia	66.0	186.5	2.4	16	4.6	4.7	6.75	10	660	26.5	1.3	24,731	190 / 175	290	24
Kenya	31.9	55.4	1.9	34	4.6	5.0	4.15	44	1,010	17.2	2.4	35,108	109 / 98	499	49
Madagascar	16.9	47.0	2.8	30	4.9	3.7	5.68	47	820		1.1	9,159	150 / 144		47
Malawi	11.8	31.1	2.2	15	4.6	4.3	6.34	56	600	8.2	2.8	16,516	224 / 223		57
Mauritius (2)	1.2	1.4	0.8	42	1.6	1.3	1.90		9,940	9.7	1.8	72	21 / 15		100
Mozambique	19.0	38.8	1.8	33	5.1	4.1	5.86	44	800		2.8	17,790	236 / 212	404	60
Rwanda	8.1	18.5	2.1	6	4.2	5.7	5.77	31	930		2.0	8,266	206 / 186		41
Somalia	9.6	40.9	4.2	28	5.8	5.7	7.25	34					193 / 178		
Uganda	24.8	101.5	3.2	15	5.7	2.6	7.10	38	1,210	7.7	1.9	37,394	167 / 151		50
United Republic of Tanzania	36.8	82.7	2.3	33	5.3	5.8	5.03	36	520		1.3	30,502	122 / 111	457	54
Zambia	10.9	29.3	2.1	40	2.7	1.3	5.66	47	750	4.7	3.6	17,092	143 / 144	626	64
Zimbabwe	13.1	23.5	1.7	36	3.7	2.3	4.50	73	2,550	19.3	3.0	17,659	112 / 104	821	85
MIDDLE AFRICA (3)	**101.1**	**340.6**	**3.0**	**36**	**4.4**		**6.33**	**55**					**155 / 139**		
Angola	13.9	53.3	3.0	35	4.8	2.6	7.20	23	1,180			5,569	211 / 191	595	38
Cameroon	15.5	32.3	2.1	50	3.6	1.1	4.70	56	1,590		1.0	1,759	138 / 127	419	62
Central African Republic	3.8	8.2	1.6	42	2.8	1.3	4.92	44	1,160		2.0	1,429	172 / 141		60
Chad	8.4	27.7	3.1	24	4.7	1.6	6.65	16	870	6.3	2.3	2,984	207 / 190		27
Congo, Democratic Republic of (4)	54.3	203.5	3.3	31	4.9	4.0	6.70	70				1,837	136 / 120	293	45
Congo, Republic of	3.2	10.7	3.0	66	4.0	5.5	6.29		570	10.7	2.0	2,217	136 / 108	245	51
Gabon	1.3	3.2	2.5	82	3.4	0.9	5.40	86	5,360		2.1	683	139 / 125	1,342	70
NORTHERN AFRICA (5)	**180.7**	**303.6**	**1.8**	**49**	**2.7**		**3.13**	**70**				**49,323** [22]	**68 / 63**		
Algeria	31.4	51.2	1.8	58	2.7	0.9	2.79	92	5,040		2.6	2,644	50 / 44	944	94
Egypt	70.3	113.8	1.7	43	1.8	7.5	2.88	61	3,670		1.8	31,821	49 / 49	709	95
Libyan Arab Jamahiriya	5.5	10.0	2.2	88	2.5	0.2	3.31	94					28 / 28	2,370	72
Morocco	31.0	50.4	1.8	56	2.9	1.2	3.03	40	3,450		1.2	8,121	58 / 46	352	82
Sudan	32.6	63.5	2.3	37	4.7	1.1	4.47	86	1,520	45.6	0.7	4,255	126 / 118	503	75
Tunisia	9.7	14.1	1.1	66	2.1	0.5	2.10	90	6,070		2.2	1,272	32 / 29	811	
SOUTHERN AFRICA	**50.6**	**56.9**	**0.8**	**55**	**2.1**		**3.03**	**83**					**115 / 104**		
Botswana	1.6	2.1	0.5	49	1.4	2.0	3.94	99	7,170		2.5	1,075	146 / 137		
Lesotho	2.1	2.5	0.7	29	3.4	2.4	4.45	60	2,590	18.1		381	182 / 180		91
Namibia	1.8	3.7	1.7	31	3.3	1.0	4.87	76	6,410		3.3	2,583	123 / 118	645	77
South Africa	44.2	47.3	0.8	58	2.1	0.4	2.85	84	9,160		3.3	19,449	107 / 95		
WESTERN AFRICA (6)	**236.5**	**608.1**	**2.7**	**40**	**4.3**		**5.57**	**40**					**148 / 144**		
Benin	6.6	18.1	2.8	43	4.5	1.8	5.68	60	980	11.6	1.6	5,929	141 / 123	323	63
Burkina Faso	12.2	46.3	3.0	17	5.1	3.0	6.80	31	970	22.2	1.5	5,796	151 / 141		
Côte d'Ivoire	16.7	32.2	2.1	44	3.0	1.1	4.64	47	1,500		1.2	4,667	144 / 131	388	77
Gambia	1.4	2.6	2.4	31	4.4	5.0	4.79	51	1,620	13.5	2.3	1,321	205 / 185		62
Ghana	20.2	40.1	2.2	36	3.1	2.0	4.22	44	1,910		1.7	22,323	106 / 93	377	64
Guinea	8.4	20.7	1.5	28	3.1	4.5	5.83	35	1,930		2.3	9,574	188 / 191		48
Guinea-Bissau	1.3	3.3	2.4	32	4.8	2.8	5.99	35	710			157	219 / 196		49
Liberia	3.3	14.4	5.5	46	6.8	5.6	6.80					1,591	118 / 106		
Mali	12.0	41.7	2.9	31	5.1	1.9	7.00	24	780	13.3	2.1	16,851	240 / 232		65
Mauritania	2.8	8.5	3.0	59	5.1	2.7	6.00	40	1,630	10.1	1.4	862	163 / 150		37
Niger	11.6	51.9	3.6	21	6.0	1.8	8.00	16	740		1.2	4,291	207 / 213		59
Nigeria	120.0	278.8	2.6	45	4.4	1.2	5.42	42	800		0.8	16,693	130 / 130	705	57
Senegal	9.9	22.7	2.5	48	4.0	3.0	5.11	51	1,480		2.6	15,198	107 / 102	318	78
Sierra Leone	4.8	14.4	4.5	37	6.3	5.0	6.50	42	480		0.9	481	266 / 242		28
Togo	4.8	11.8	2.6	34	4.2	1.2	5.36	51	1,410	8.8	1.3	1,540	132 / 116	313	54
ASIA	**3,768.6**	**5,428.2**	**1.3**	**38**	**2.7**		**2.54**	**59**				**415,124**	**68 / 73**		
EASTERN ASIA (7)	1,502.0	1,665.2	0.7	43	2.6		1.76	90					35 / 42		
China	1,294.4	1,462.1	0.7	37	3.2	6.3	1.80	89	3,920	6.5	2.1	11,465	38 / 45	868	75
Democratic People's Republic of Korea	22.6	28.0	0.7	61	1.2	3.4	2.07					561	52 / 48	2,658	100
Hong Kong SAR, China (9)	7.0	9.6	1.2	100	1.2	5.3	1.17	100	25,590	7.8			5 / 5	2,661	
Japan	127.5	109.2	0.1	79	0.4	1.1	1.33	100	27,080	19.0	5.7	(111,691) [23]	5 / 4	4,070	
Mongolia	2.6	4.1	1.1	57	1.3	0.5	2.32	97	1,760			3,956	88 / 83		40
Republic of Korea	47.4	51.6	0.7	83	1.3	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

	Total population (millions) (2002)	Projected population (millions) (2050)	Ave. pop. growth rate (%) (2000-2005)	% urban (2001)	Urban growth rate (2000-2005)	Pop./ ha arable & perm. crop land	Total fertility rate (2000-2005)	% births with skilled attendants	GNI per capita PPP$ (2000)	Expndtrs/ primary student (% of GDP per capita)	Health expenditures public (% of GDP)	External population assistance (US$,000)	Under 5 mortality M/F	Per capita energy consumption	Access to safe water
SOUTH-EASTERN ASIA	**537.3**	**800.3**	**1.4**	**38**	**3.3**		**2.52**	**61**					**60 / 48**		
Cambodia	13.8	29.9	2.4	18	5.5	2.4	4.77	34	1,440		0.6	21,362	110 / 98		30
Indonesia	217.5	311.3	1.2	42	3.6	3.0	2.27	56	2,830		0.8	38,285	55 / 43	658	76
Lao People's Democratic Republic	5.5	11.4	2.3	20	4.6	4.1	4.80	21	1,540	6.5	1.2	2,104	144 / 137		90
Malaysia	23.0	37.8	1.7	58	2.9	0.5	2.90	96	8,330	10.7	1.4	670	15 / 11	1,878	
Myanmar	49.0	68.5	1.2	28	2.9	3.3	2.80			3.5	0.2	1,886	141 / 124	273	68
Philippines	78.6	128.4	1.9	59	3.2	2.9	3.24	56	4,220	9.3	1.6	47,144	40 / 30	549	87
Singapore	4.2	4.6	1.7	100	1.7	7.0	1.45	100	24,910		1.1	0	6 / 6	5,742	100
Thailand	64.3	82.5	1.1	20	2.1	1.7	2.00	85	6,320	11.9	1.9	11,039	32 / 19	1,169	80
Viet Nam	80.2	123.8	1.3	25	3.1	7.1	2.25	70	2,000	7.3	0.8	17,039	52 / 37	454	56
SOUTH CENTRAL ASIA	**1,532.6**	**2,538.8**	**1.7**	**30**	**2.6**		**3.25**	**38**					**89 / 100**		
Afghanistan	23.3	72.3	3.7	22	5.7	1.8	6.80					1,937	278 / 281		13
Bangladesh	143.4	265.4	2.1	26	4.3	9.0	3.56	12	1,590		1.7	89,494	88 / 97	139	97
Bhutan	2.2	5.6	2.6	7	5.9	11.9	5.10	15			3.2	1,274	82 / 78		62
India	1,041.1	1,572.1	1.5	28	2.3	3.2	2.97	42	2,340	8.4	0.8	57,247	79 / 92	482	88
Iran (Islamic Republic of)	72.4	121.4	1.4	65	2.4	1.0	2.76		5,910	8.0	1.7	1,249	40 / 45	1,651	95
Nepal	24.2	52.4	2.3	12	5.1	7.1	4.48	12	1,370	9.3	1.3	25,073	91 / 106	358	81
Pakistan	148.7	344.2	2.5	33	3.5	3.2	5.08	20	1,860		0.7	28,144	121 / 135	444	88
Sri Lanka	19.3	23.1	0.9	23	2.4	4.6	2.09	94	3,460		1.7	2,804	30 / 16	406	83
WESTERN ASIA	**196.6**	**423.9**	**2.1**	**65**	**2.5**		**3.57**	**72**				**28,981**	**53 / 47**		
Iraq	24.2	53.6	2.7	67	2.7	0.4	4.47				3.8	313	79 / 76	1,263	85
Israel	6.3	10.1	2.0	92	2.2	0.4	2.70		19,330	20.3	6.0	22	9 / 9	3,029	
Jordan	5.2	11.7	2.8	79	3.0	1.4	4.31	97	3,950		3.6	9,856	29 / 27	1,028	96
Kuwait	2.0	4.0	2.6	96	2.6	3.0	2.66	98	18,690	23.6	2.9	12	13 / 13	8,984	
Lebanon	3.6	5.0	1.6	90	1.9	0.4	2.18	88	4,550		2.2	2,278	22 / 17	1,280	100
Occupied Palestinian Territory	3.4	11.8	3.6	67	4.1		5.60					2,354	27 / 21		
Oman	2.7	8.8	3.3	77	4.0	11.7	5.46	91		8.9	2.9	10	29 / 25	3,607	39
Saudi Arabia	21.7	59.7	3.1	87	3.6	0.5	5.54	91	11,390		6.4	0	26 / 23	4,204	95
Syrian Arab Republic	17.0	36.3	2.5	52	3.3	0.8	3.65	76	3,340		0.9	1,968	28 / 25	1,143	80
Turkey (11)	68.6	98.8	1.3	66	1.9	0.8	2.30	81	7,030	13.3	3.3	6,480	56 / 42	1,093	83
United Arab Emirates	2.7	3.7	1.7	87	2.2	1.0	2.86	99			0 8	0	16 / 14	9,977	
Yemen	19.9	102.4	4.1	25	5.3	5.5	7.60	22	770		2.4	5,690	87 / 83	184	69
EUROPE	**725.1**	**603.3**	**-0.2**	**74**	**0.3**		**1.34**	**99**					**13 / 10**		
EASTERN EUROPE	301.0	222.7	-0.5	68	-0.5		1.17	99				27,196 [22 24]	21 / 16		
Bulgaria	7.8	4.5	-1.0	70	-0.9	0.1	1.10		5,560	29.6	3.9	275	22 / 16	2,218	100
Czech Republic	10.3	8.4	-0.1	67	0.0	0.3	1.16		13,780	13 0	6.6	0	7 / 7	3,754	
Hungary	9.9	7.5	-0.5	65	-0.1	0.2	1.20		11,990	17.9	5.2	0	12 / 10	2,512	99
Poland	38.5	33.4	-0.1	63	0.3	0.5	1.26		9,000	16.7	4.7	205	11 / 10	2,416	
Romania	22.3	18.1	-0.3	55	0.1	0.3	1.32	98	6,360	19.9	3.8	1,952	29 / 25	1,622	58
Slovakia	5.4	4.7	0.1	58	0.4	0.3	1.28		11,040	21.8	5.7	0	10 / 10	3,335	100
NORTHERN EUROPE (12)	**95.4**	**92.8**	**0.1**	**84**	**0.2**		**1.57**	**99**					**7 / 6**		
Denmark	5.3	5.1	0.2	85	0.2	0.1	1.65		27,250	24.1	6.9	(54,877)	7 / 6	3,773	100
Estonia	1.4	0.8	-1.1	69	-1.1	0.1	1.20		9,340		5.1	30	14 / 10	3,286	
Finland	5.2	4.7	0.1	59	0.1	0.1	1.55		24,570	21.9	5.2	(19,957)	5 / 4	6,461	100
Ireland	3.9	5.4	1.0	59	1.4	0.4	2.02		25,520	11.6	5.2	(2,673)	8 / 8	3,726	
Latvia	2.4	1.7	-0.6	60	-0.6	0.2	1.10	100	7,070		4.0	31	19 / 15	1,586	
Lithuania	3.7	3.0	-0.2	69	0.0	0.2	1.20		6,980		4.5	24	14 / 10	2,138	
Norway	4.5	4.9	0.4	75	0.7	0.3	1.70		29,630	27.6	7.0	(61,671)	6 / 5	5,965	100
Sweden	8.8	7.8	-0.1	83	-0.1	0.1	1.29		23,970	26.2	6.6	(61,602)	5 / 4	5,769	100
United Kingdom	59.7	58.9	0.2	90	0.3	0.2	1.61	99	23,550	17.2	5.8	(95,703)	7 / 6	3,871	100
SOUTHERN EUROPE (13)	**145.1**	**116.9**	**0.0**	**67**	**0.4**		**1.29**	**100**					**10 / 9**		
Albania	3.2	3.9	0.6	43	2.1	2.2	2.27	99	3,600	9.5	2.0	3,342	37 / 31	311	
Bosnia & Herzegovina	4.1	3.5	1.1	43	2.2	0.3	1.30	100			8.0	317	17 / 14	518	
Croatia	4.7	4.2	0.0	58	0.8	0.3	1.70		7,960		9.5	0	10 / 8	1,864	
Greece	10.6	9.0	0.0	60	0.5	0.4	1.24		16,860		4.7		8 / 7	2,552	
Italy	57.4	43.0	-0.1	67	0.1	0.3	1.20		23,470	21.7	5.6	(13,508)	7 / 6	2,932	
Macedonia (Former Yugoslav Republic of)	2.1	1.9	0.3	59	0.4	0.4	1.48		5,020	19.1	5.3		19 / 18		
Portugal	10.0	9.0	0.1	66	1.9	0.5	1.45	100	16,990	18.7	5.1	(440)	9 / 8	2,365	
Slovenia	2.0	1.5	-0.1	49	-0.1	0.2	1.14		17,310	20.6	6.7	0	8 / 7	3,277	100
Spain	39.9	31.3	0.0	78	0.3	0.2	1.13		19,260	16.4	5.4	(9,466)	7 / 6	3,005	
Yugoslavia	10.5	9.0	-0.1	52	0.2	0.6	1.55					800	17 / 14	1,258	

Demographic, Social and Economic Indicators

	Total population (millions) (2002)	Projected population (millions) (2050)	Ave. pop. growth rate (%) (2000–2005)	% urban (2001)	Urban growth rate (2000–2005)	Pop./ ha arable & perm. crop land	Total fertility rate (2000–2005)	% births with skilled attendants	GNI per capita PPP$ (2000)	Expndtrs/ primary student (% of GDP per capita)	Health expenditures public (% of GDP)	External population assistance (US$,000)	Under 5 mortality M/F	Per capita energy consumption	Access to safe water
WESTERN EUROPE (14)	**183.7**	**170.9**	**0.1**	**83**	**0.3**		**1.50**	**100**					**6 / 6**		
Austria	8.1	6.5	-0.1	67	0.2	0.3	1.24		26,330	21.4	5.9	(1,449)	6 / 5	3,513	100
Belgium	10.3	9.6	0.1	97	0.2	0.2 [25]	1.48		27,470	8.5	6.3	(10,443)	6 / 6	5,735	
France	59.7	61.8	0.4	76	0.6	0.1	1.80		24,420	15.8	7.3	(7,977)	6 / 6	4,351	
Germany	82.0	70.8	0.0	88	0.2	0.2	1.29		24,920		7.9	(119,764) [26]	6 / 6	4,108	
Netherlands	16.0	15.8	0.3	90	0.5	0.6	1.50	100	25,850	14.1	6.0	(115,781)	7 / 6	4,686	100
Switzerland	7.2	5.6	-0.1	68		1.1	1.38		30,450	20.1	7.6	(17,796)	7 / 5	3,738	100
LATIN AMERICA & CARIBBEAN	**534.2**	**805.6**	**1.4**	**76**	**1.9**		**2.50**	**81**				**182,603**	**45 / 36**		
CARIBBEAN (15)	**38.7**	**49.8**	**1.0**	**63**	**1.6**		**2.41**	**73**					**60 / 50**		
Cuba	11.3	10.8	0.3	76	0.5	0.4	1.55	100		16.3		540	12 / 8	1,117	95
Dominican Republic	8.6	12.0	1.5	66	2.4	1.0	2.71	96	5,710	2.8	1.9	8,163	57 / 47	904	79
Haiti	8.4	14.0	1.6	36	3.3	5.5	3.98	24	1,470		1.4	20,222	111 / 96	265	46
Jamaica	2.6	3.8	0.9	57	1.8	2.0	2.37	95	3,440	11.8	3.0	4,209	28 / 21	1,597	71
Puerto Rico	4.0	4.8	0.9	76	1.3	1.5	1.90	100				0	14 / 11		
Trinidad & Tobago	1.3	1.4	0.5	75	1.0	0.9	1.53	99	8,220	4.8	2.5	234	17 / 12	6,205	86
CENTRAL AMERICA	**139.8**	**220.2**	**1.6**	**69**	**2.0**		**2.76**	**76**					**41 / 34**		
Costa Rica	4.2	7.2	2.0	60	2.9	1.7	2.67	98	7,980	8.2	5.2	313	15 / 11	818	98
El Salvador	6.5	10.9	1.8	62	3.5	2.6	2.88	51	4,410	7.0	2.6	9,105	38 / 31	651	74
Guatemala	12.0	26.6	2.6	40	3.4	2.9	4.41	41	3,770	6.1	2.1	10,411	58 / 51	548	92
Honduras	6.7	12.8	2.3	54	4.0	1.2	3.72	54	2,400		3.9	8,864	55 / 44	522	90
Mexico	101.8	146.7	1.4	75	1.7	0.9	2.49	86	8,790	6.4	2.6	14,924	37 / 31	1,543	86
Nicaragua	5.3	11.5	2.6	57	3.3	0.4	3.82	65	2,080	12.6	8.5	9,954	50 / 40	539	79
Panama	2.9	4.3	1.4	57	2.0	1.0	2.42	90	5,680		4.9	244	26 / 22	835	87
SOUTH AMERICA (16)	**355.7**	**535.5**	**1.4**	**80**	**1.9**		**2.41**	**85**					**45 / 35**		
Argentina	37.9	54.5	1.2	88	1.4	0.1	2.44	98	12,050	9.0	2.4	1,558	26 / 21	1,727	79
Bolivia	8.7	17.0	2.2	63	3.0	1.6	3.92	59	2,360	10.9	4.1	19,230	80 / 70	562	79
Brazil	174.7	247.2	1.2	82	1.9	0.4	2.15	88	7,300	11.0	2.9	12,595	50 / 38	1,068	87
Chile	15.6	22.2	1.2	86	1.5	1.1	2.35	100	9,100	10.5	2.7	415	15 / 12	1,688	94
Colombia	43.5	70.9	1.6	76	2.3	2.0	2.62	86	6,060		5.2	2,181	35 / 30	676	91
Ecuador	13.1	21.2	1.7	63	2.4	1.2	2.76	69	2,910		1.7	7,555	60 / 49	705	71
Paraguay	5.8	12.6	2.5	57	3.6	1.0	3.84	58	4,450	10.9	1.7	4,292	51 / 39	773	79
Peru	26.5	42.1	1.6	73	2.1	1.8	2.64	56	4,660	4.8	2.4	22,112	61 / 50	519	77
Uruguay	3.4	4.2	0.7	92	0.9	0.3	2.30	99	8,880		1.9	461	18 / 13	976	98
Venezuela	25.1	42.2	1.8	87	2.1	0.7	2.72	95	5,740	2.1	2.6	448	25 / 20	2,253	84
NORTHERN AMERICA (17)	**319.9**	**437.6**	**0.9**	**78**	**1.2**		**1.90**	**99**					**8 / 8**		
Canada	31.3	40.4	0.8	79	1.1	0.0	1.58	98	27,170		6.6	(37,212)	7 / 6	7,929	100
United States of America	288.5	397.1	0.9	77	1.2	0.0	1.93	99	34,100	18.0	5.7	(603,003)	8 / 8	8,159	100
OCEANIA	**31.3**	**47.2**	**1.2**	**74**	**1.5**		**2.39**	**86**					**32 / 33**		
AUSTRALIA-NEW ZEALAND	**23.4**	**30.9**	**0.9**	**90**	**1.3**		**1.79**	**100**					**7 / 6**		
Australia (18)	19.5	26.5	1.0	91	1.4	0.0	1.75	100	24,970	14.0	6.0	(30,530)	7 / 6	5,690	100
Melanesia (19)	6.8	14.2	2.2	24	3.5		4.14	63					68 / 74		
New Zealand	3.8	4.4	0.7	86	0.9	0.1	1.97	100	18,530	16.6	6.3	(2,316)	8 / 7	4,770	
Papua New Guinea	5.0	11.0	2.2	18	3.7	5.4	4.32	53	2,180		2.5	7,288	81 / 88		42
COUNTRIES WITH ECONOMIES IN TRANSITION OF THE FORMER USSR (20)															
Armenia	3.8	3.2	0.1	67	0.2	0.9	1.10	97	2,580		4.0	520	19 / 17	485	
Azerbaijan	8.1	8.9	0.6	52	0.6	1.1	1.51	88	2,740	21.6	1.0	941	41 / 38	1,575	
Belarus	10.1	8.3	-0.4	70	-0.2	0.2	1.20		7,550	45.8	4.6	15	18 / 13	2,381	100
Georgia	5.2	3.2	-0.5	57	-0.1	1.0	1.39	96	2,680		0.8	746	25 / 18	512	
Kazakhstan	16.0	15.3	-0.4	56	-0.3	0.1	1.95	99	5,490		2.7	2,809	62 / 42	2,374	91
Kyrgyzstan	5.0	7.5	1.2	34	1.2	0.9	2.34	98	2,540		2.2	1,402	50 / 42	504	77
Republic of Moldova	4.3	3.6	-0.3	41	0.0	0.5	1.40	99	2,230		2.9	422	28 / 22	656	100
Russian Federation	143.8	104.3	-0.6	73	-0.6	0.1	1.14		8,010		4.6	10,025	24 / 18	4,121	99
Tajikistan	6.2	9.8	0.7	28	0.7	2.4	2.87	77	1,090		5.2	892	82 / 70	543	
Turkmenistan	4.9	8.4	1.9	45	2.3	0.9	3.17	97	3,800		4.1	719	74 / 61	2,677	
Ukraine	48.7	30.0	-0.9	68	-0.8	0.2	1.10	99	3,700	42.4	2.9	3,702	22 / 16	2,973	
Uzbekistan	25.6	40.5	1.4	37	1.4	1.4	2.29	96	2,360		3.4	2,592	56 / 48	2,004	85

Selected Indicators for Less Populous Countries/Territories

Monitoring ICPD Goals – Selected Indicators

	Indicators of Mortality			Indicators of Education		Reproductive Health Indicators			
	Infant mortality Total per 1,000 live births	Life expectancy M/F	Maternal Mortality Ratio	Primary enrolment (gross) M/F	Secondary enrolment (gross) M/F	Births per 1,000 women aged 15-19	Contraceptive prevalence Any method	Contraceptive prevalence Modern methods	HIV prevalence rate (%) (15-24) M/F
Bahamas	17	65.2 / 73.9	10	95 / 92		61	62	60	2.64 / 3.03
Bahrain	14	72.1 / 76.3	38	104 / 104	89 / 98	18	62	31	
Barbados	11	74.5 / 79.5	33	88 / 87	102 / 108	43	55	53	
Belize	30	73.0 / 75.9	140	115 / 111	50 / 58	79	47	42	1.10 / 1.99
Brunei Darussalam	9	74.2 / 78.9	22	109 / 104	100 / 111	30			
Cape Verde	50	67.0 / 72.8	190	146 / 143		72	53	46	
Comoros	67	59.4 / 62.2	570	82 / 70	27 / 22	77	21	11	
Cyprus	8	76.0 / 80.5		83 / 83	81 / 85	10			
Djibouti	117	39.4 / 41.6	520	46 / 32	19 / 13	65			
East Timor	121	49.2 / 50.9	850			27			
Equatorial Guinea	99	50.4 / 53.6	1,400	146 / 115		192			1.40 / 2.77
Fiji	17	68.1 / 71.5	20	113 / 111		54	41	35	
French Polynesia	9	70.7 / 75.8	20			58			
Guadaloupe	7	74.8 / 81.7	5			18	44	31	
Guam	10	72.4 / 77.0	12			109			
Guyana	52	58.0 / 66.9	150	103 / 101	78 / 79	64	31	28	3.28 / 4.01
Iceland	5	77.1 / 81.8	16	101 / 98	107 / 113	18			
Luxembourg	6	74.6 / 80.9		104 / 105	96 / 99	9			
Maldives	37	68.3 / 67.0	390			53			
Malta	7	75.9 / 81.0		107 / 107	98 / 87	12			
Martinique	7	75.8 / 82.3	4			27	51	38	
Micronesia (27)	19	71.0 / 75.5				78			
Netherlands Antilles	13	73.3 / 79.2	20	120 / 114	70 / 82	45			
New Caledonia	7	72.5 / 77.7	10			31			
Polynesia (28)	17	69.2 / 74.8	33			53			
Qatar	11	69.4 / 72.1	41	98 / 93	68 / 90	36	43	32	
Reunion	8	70.6 / 79.1	39			20	67	62	
Samoa	26	66.9 / 73.5	15	101 / 102	59 / 66	46			
Solomon Islands	21	67.9 / 70.7	60			87			
Suriname	26	68.5 / 73.7	230			16			1.22 / 1.52
Swaziland	92	38.1 / 38.1	370	121 / 114	56 / 55	81	20	17	15.23 / 39.49
Vanuatu	29	67.5 / 70.5	32	116 / 111	21 / 25	54			

Demographic, Social and Economic Indicators

	Total population (thousands) 2002	Projected population (thousands) 2050	% urban (2001)	Urban growth rate (2000-2005)	Population/ ha arable & perm. crop land	Total fertility rate (2000-2005)	% births with skilled attendants	GNI per capita PPP$ (2000)	Under 5 mortality M/F
Bahamas	312	449	88.9	1.6	1.1	2.31	99	16,400	26 / 20
Bahrain	663	1,008	92.5	2.0	1.2	2.28	98		22 / 15
Barbados	269	263	50.5	1.4	0.7	1.50	91	15,020	13 / 11
Belize	236	392	48.1	2.2	0.8	2.89	77	5,240	39 / 38
Brunei Darussalam	341	565	72.8	2.5	0.4	2.53	99		10 / 10
Cape Verde	446	807	63.5	3.9	2.4	3.24	53	4,760	60 / 53
Comoros	749	1,900	33.8	4.6	4.3	4.96	62	1,590	96 / 87
Cyprus	797	910	70.2	1.2	0.5	1.92		20,780	8 / 8
Djibouti	652	1,068	84.2	1.3		5.77			210 / 194
East Timor	779	1,410	7.5	4.7	7.7	3.85	71		182 / 174
Equatorial Guinea	483	1,378	49.3	4.9	1.4	5.89		5,600	167 / 153
Fiji	832	916	50.2	2.5	1.1	2.98	100	4,480	20 / 24
French Polynesia	241	372	52.6	1.6		2.47	99	23,340	11 / 11
Guadaloupe	435	479	99.6	0.8	0.6	2.02			11 / 8
Guam	162	307	39.5	3.0		3.95	100		13 / 10
Guyana	765	504	36.7	1.4	0.3	2.31	95	3,670	80 / 60
Iceland	283	333	92.7	0.8	3.4	1.90		28,710	7 / 5
Luxembourg	448	715	91.9	1.6	0.2 [25]	1.76		45,470	7 / 7
Maldives	309	868	28.0	4.6	26.3	5.37		4,240	38 / 56
Malta	393	400	91.2	0.7	0.8	1.77		16,530	9 / 8
Martinique	388	413	95.2	0.8	0.7	1.70			9 / 8
Micronesia (27)	540	1,080	28.6	3.6		4.11	93		24 / 23
Netherlands Antilles	219	259	69.3	1.1	0.1	2.09			17 / 11
New Caledonia	224	397	78.1	3.2		2.47	98	21,820	9 / 10
Polynesia (28)	621	958	40.4	1.9		3.01	99		22 / 20
Qatar	584	831	92.9	1.7	0.4	3.34			16 / 11
Reunion	742	1,002	72.1	2.2	0.7	2.14			12 / 10
Samoa	159	223	22.3	1.4		4.24	100	5,050	34 / 29
Solomon Islands	479	1,458	20.2	6.0	5.3	5.26	85	1,710	31 / 30
Suriname	421	418	74.8	1.3	1.2	2.05	85	3,480	35 / 23
Swaziland	948	1,391	26.7	2.2	1.7	4.44	55	4,600	178 / 163
Vanuatu	207	462	22.1	4.2		4.26	89	2,960	32 / 39

Notes for Indicators

NOTES FOR INDICATORS

The designations employed in this publication do not imply the expression of any opinion on the part of the United Nations Population Fund concerning the legal status of any country, territory or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Data for small countries or areas, generally those with population of 200,000 or less in 1990, are not given in this table separately. They have been included in their regional population figures.

(*) More-developed regions comprise North America, Japan, Europe and Australia-New Zealand.

(+) Less-developed regions comprise all regions of Africa, Latin America and Caribbean, Asia (excluding Japan), and Melanesia, Micronesia and Polynesia.

(‡) Least-developed countries according to standard United Nations designation.

(1) Including British Indian Ocean Territory and Seychelles.

(2) Including Agalesa, Rodrigues and St. Brandon.

(3) Including Sao Tome and Principe.

(4) Formerly Zaire.

(5) Including Western Sahara.

(6) Including St. Helena, Ascension and Tristan da Cunha.

(7) Regional averages and totals exclude Japan and Australia-New Zealand.

(8) Including Macau.

(9) On 1 July 1997, Hong Kong became a Special Administrative Region (SAR) of China.

(10) This entry is included in the more developed regions aggregate but not in the estimate for the geographical region.

(11) Turkey is included in Western Asia for geographical reasons. Other classifications include this country in Europe.

(12) Including Channel Islands, Faeroe Islands and Isle of Man.

(13) Including Andorra, Gibraltar, Holy See and San Marino.

(14) Including Leichtenstein and Monaco.

(15) Including Anguilla, Antigua and Barbuda, Aruba, British Virgin Islands, Cayman Islands, Dominica, Grenada, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Turks and Caicos Islands, and United States Virgin Islands.

(16) Including Falkland Islands (Malvinas) and French Guiana.

(17) Including Bermuda, Greenland and St. Pierre and Miquelon.

(18) Including Christmas Island, Cocos (Keeling) Islands and Norfolk Island.

(19) Including New Caledonia and Vanuatu.

(20) The successor States of the former USSR are grouped under existing regions. Eastern Europe includes Belarus, Republic of Moldova, Russian Federation and Ukraine. Western Asia includes Armenia, Azerbaijan and Georgia. South Central Asia includes Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. Regional total, excluding subregion reported separately below.

(21) Regional total, excluding subregion reported separately below.

(22) These subregions are included in the UNFPA Arab States and Europe region.

(23) Estimates based on previous years' reports. Updated data are expected.

(24) Total for Eastern Europe includes some South European Balkan States and Northern European Baltic States.

(25) This figure includes Belgium and Luxembourg.

(26) More recent reports suggest this figure might have been higher. Future publications will reflect the evaluation of this information.

(27) Comprising Federated States of Micronesia, Guam, Kiribati, Marshall Islands, Nauru, Northern Mariana Islands, Pacific Islands (Palau) and Wake Island.

(28) Comprising American Samoa, Cook Islands, Johnston Island, Pitcairn, Samoa, Tokelau, Tonga, Midway Islands, Tuvalu, and Wallis and Futuna Islands.

The statistical tables in this year's *State of World Population* report once again give special attention to indicators that can help track progress in meeting the quantitative and qualitative goals of the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs) in the areas of mortality reduction, access to education, access to reproductive health services including family planning, and HIV/AIDS prevalence among young people. Several changes have been made in other indicators, as noted below. Future reports will include different process measures when these become available, as ICPD and MDG follow-up efforts lead to improved monitoring systems. Improved monitoring of the financial contributions of governments, non-governmental organizations and the private sector should also allow better future reporting of expenditures and resource mobilization for ICPD/MDG implementation efforts. The sources for the indicators and their rationale for selection follow, by category.

Monitoring ICPD goals

INDICATORS OF MORTALITY

Infant mortality, male and female life expectancy at birth. Source: United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision* (Data diskettes, "Demographic Indicators 1950-2050"). New York: United Nations. These indicators are measures of mortality levels, respectively, in the first year of life (which is most sensitive to development levels) and over the entire lifespan.

Maternal mortality ratio. Source: Kenneth Hill, Carla AbouZahr, & Tessa Wardlaw. "Estimates of Maternal Mortality for 1995." *Bulletin of the World Health Organization* 79(3): 182-193. Geneva: World Health Organization. These are consensus estimates of WHO, UNICEF and UNFPA. This indicator presents the number of deaths to women per 100,000 live births which result from conditions related to pregnancy, delivery and related complications. Precision is difficult, though relative magnitudes are informative. Estimates below 50 are not rounded; those 50-100 are rounded to the nearest 5; 100-1,000, to the nearest 10; and above 1,000, to the nearest 100. Several of the estimates differ from official government figures. The estimates are based on reported figures wherever possible, using approaches to improve the comparability of information from different sources. See the source for details on the origin of particular national estimates. Estimates and methodologies are regularly reviewed by WHO, UNICEF, UNFPA, academic institutions and other agencies and are revised where necessary, as part of the ongoing process of improving maternal mortality data. Because of changes in methods, prior estimates for 1990 levels may not be strictly comparable with these estimates.

INDICATORS OF EDUCATION

Male and female gross primary enrolment ratios, male and female gross secondary enrolment ratios. Source: Spreadsheets provided by UNESCO (data to be published in the series) *UNESCO Statistical Yearbook* and *World Education Report*. Montreal: UNESCO Institute for Statistics (www.unesco.org/statistics). Gross enrolment ratios indicate the number of students enrolled in a level in the education system per 100 individuals in the appropriate age group. They do not correct for individuals who are older than the level-appropriate age due to late starts, interrupted schooling or grade repetition.

Male and female adult illiteracy. Source: Spreadsheets provided by UNESCO (data to be published in the *Education for All: Status and Trends* series. Montreal: UNESCO website: www.unesco.org/statistics). Illiteracy definitions are subject to variation in different countries; three widely accepted definitions are in use. In so far as possible, data refer to the proportion who cannot, with understanding, both read and write a short simple statement on everyday life. Adult illiteracy (rates for persons above 15 years of age) reflects both recent levels of educational enrolment and past educational attainment. The above education indicators have been updated using the UN Population Division estimates from *World Population Prospects* (The 1998 Revision). Data are Estimates and projections for 2002.

Proportion completing final grade of primary education. Source: World Bank. 2002. *World Development Indicators 2002*. Washington, D.C.: Development Data Center, the World Bank, based on data provided by UNESCO (Montreal: UNESCO Institute for Statistics). Data are most recent within the years 1992-2000.

INDICATORS OF REPRODUCTIVE HEALTH

Births per 1,000 women aged 15-19. Source: United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision* (Data diskettes, "Demographic Indicators 1950-2050"); and United Nations Population Division. 2000. *Age Patterns of Fertility: The 2000 Revision*. New York: United Nations. This is an indicator of the burden of fertility on young women. Since it is an annual level summed over all women in the age cohort, it does not reflect fully the level of fertility for women during their youth. Since it indicates the annual average number of births per woman per year, one could multiply it by five to approximate the number of births to 1,000 young women during their late teen years. The measure does not indicate the full dimensions of teen pregnancy as only live births are included in the numerator. Stillbirths and spontaneous or induced abortions are not reflected.

Contraceptive prevalence. Source: United Nations Population Division. 2002. *Database on Contraceptive Use* (updated June 2002). New York: United Nations. These data are derived from sample survey reports and estimate the proportion of married women

(including women in consensual unions) currently using, respectively, any method or modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods. These numbers are roughly but not completely comparable across countries due to variation in the timing of the surveys, and in the details of the questions. Unlike in past years, all country and regional data refer to women aged 15-49. All of the data were collected in 1972 or later. The most recent survey data available are cited; 80 per cent of the data refer to the period 1990-2000.

HIV prevalence rate, M/F, 15-24. Source: UNAIDS. 2000. Country HIV/AIDS information spreadsheet on UNAIDS web site. These data derive from surveillance system reports and model estimates. Data provided for men and women aged 15-24 are, respectively, averages of High and Low Estimates for each country. The reference year is 1999. Male-female differences reflect physiological and social vulnerability to the illness and are affected by age differences between sexual partners.

DEMOGRAPHIC, SOCIAL AND ECONOMIC INDICATORS

Total population 2002, projected population 2050, average annual population growth rate for 2000-2005. Source: United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision* (Data diskettes, "Demographic Indicators 1950-2050"; and United Nations Population Division. 2001. *Annual Populations 1950-2050: The 2000 Revision*. New York: United Nations.) These indicators present the size, projected future size and current period annual growth of national populations.

Per cent urban, urban growth rates. Source: United Nations Population Division. 2002. *World Urbanization Prospects: The 2001 Revision: Data Tables and Highlights* (ESA/P/WP.173.) New York: United Nations. These indicators reflect the proportion of the national population living in urban areas and the growth rate in urban areas projected for 2000-2005.

Agricultural population per hectare of arable and permanent crop land. Source: Data provided by Food and Agriculture Organization (from FAO Statistical Development Service), using agricultural population data based on the total populations from United Nations Population Division. 1999. *World Population Prospects: The 1998 Revision*. New York: United Nations. This indicator relates the size of the agricultural population to the land suitable for agricultural production. It is responsive to changes in both the structure of national economies (proportions of the workforce in agriculture) and in technologies for land development. High values can be related to stress on land productivity and to fragmentation of land holdings. However, the measure is also sensitive to differing development levels and land use policies. Data refer to the year 1999.

Total fertility rate (period: 2000-2005). Source: United Nations Population Division. 2000. *World Population Prospects: The 2000 Revision* (Data diskettes, "Demographic Indicators 1950-2050"). New York: United Nations. The measure indicates the number of children a woman would have during her reproductive years if she bore children at the rate estimated for different age groups in the specified time period. Countries may reach the projected level at different points within the period.

Births with skilled attendants. Source: World Health Organization; updated information for less developed countries/regions provided by WHO (2001 Global Estimates, as of February 2002). Data for more developed countries are not available. This indicator is based on national reports of the proportion of births attended by "skilled health personnel or skilled attendant: doctors (specialist or non-specialist) and/or persons with midwifery skills who can diagnose and manage obstetrical complications as well as normal deliveries". Data for more developed countries reflect their higher levels of skilled delivery attendance. Because of assumptions of full coverage, data (and coverage) deficits of marginalized populations and the impacts of chance and transport delays may not be fully reflected in official statistics. Data estimates are the most recent available.

Gross national income per capita. Source: 2000 figures from: The World Bank. 2002. *World Development Indicators 2002*. Washington, D.C.: The World Bank. (Less-populous countries provided by Ed Bos, World Bank.) This indicator (formerly referred to as gross national product [GNP] per capita) measures the total output of goods and services for final use produced by residents and non-residents, regardless of allocation to domestic and foreign claims, in relation to the size of the population. As such, it is an indicator of the economic productivity of a nation. It differs from gross domestic product (GDP) by further adjusting for income received from abroad for labour and capital by residents, for similar payments to non-residents, and by incorporating various technical adjustments including those related to exchange rate changes over time. This measure also takes into account the differing purchasing power of currencies by including purchasing power parity (PPP) adjustments of "real GNP". Some PPP figures are based on regression models; others are extrapolated from the latest International Comparison Programme benchmark estimates; see original source for details.

Central government expenditures on education and health. Source: The World Bank. 2002. *World Development Indicators 2002*. Washington, D.C.: The World Bank. These indicators reflect the priority afforded to education and health sectors by a country through the government expenditures dedicated to them. They are not sensitive to differences in allocations within sectors, e.g., primary education or health services in relation to other levels, which vary considerably. Direct comparability is complicated by the different administrative and budgetary responsibilities allocated to central governments in relation to local governments, and to the varying roles of the private and public sectors. Reported estimates are presented as shares of GDP per capita (for education) or total

GDP (for health). Great caution is also advised about cross-country comparisons because of varying costs of inputs in different settings and sectors. Data refer to the most recent estimates 1997-1999.

External assistance for population. Source: UNFPA. 2001. *Financial Resource Flows for Population Activities in 1999*. New York: UNFPA. This figure provides the amount of external assistance expended in 1999 for population activities in each country. External funds are disbursed through multilateral and bilateral assistance agencies and by non-governmental organizations. Donor countries are indicated by their contributions being placed in parentheses. Future editions of this report will use other indicators to provide a better basis for comparing and evaluating resource flows in support of population and reproductive health programmes from various national and international sources. Regional totals include both country-level projects and regional activities (not otherwise reported in the table).

Under-5 mortality. Source: United Nations Population Division, special tabulation based on United Nations. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations. This indicator relates to the incidence of mortality to infants and young children. It reflects, therefore, the impact of diseases and other causes of death on infants, toddlers and young children. More standard demographic measures are infant mortality and mortality rates for 1 to 4 years of age, which reflect differing causes of and frequency of mortality in these ages. The measure is more sensitive than infant mortality to the burden of childhood diseases, including those preventable by improved nutrition and by immunization programmes. Under-5 mortality is here expressed as deaths to children under 5 per 1,000 live births in a given year. The estimate refers to the period 2000-2005.

Per capita energy consumption. Source: The World Bank. 2002. *World Development Indicators 2002*. Washington, D.C.: The World Bank. This indicator reflects annual consumption of commercial primary energy (coal, lignite, petroleum, natural gas and hydro, nuclear and geothermal electricity) in kilograms of oil equivalent per capita. It reflects the level of industrial development, the structure of the economy and patterns of consumption. Changes over time can reflect changes in the level and balance of various economic activities and changes in the efficiency of energy use (including decreases or increases in wasteful consumption). Data are for 1999.

Access to safe water. Source: WHO/UNICEF. 2001. *Global Water Supply and Sanitation Assessment 2000 Report* (available on the UNICEF website). This indicator reports the percentage of the population with *access* to an *adequate amount* of *safe* drinking water located within a *convenient distance* from the user's dwelling. The italicized words use country-level definitions. It is related to exposure to health risks, including those resulting from improper sanitation. Data are estimates for the year 2000.

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The State of World Population 2002

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